SEX DIFFERENCES IN PSYCHIATRIC
DIAGNOSIS AND TREATMENT

SEX DIFFERENCE IN PSYCHIATRIC DIAGNOSIS AND TREATMENT

Ву

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ABSTRACT

This study addresses differential diagnosis and treatment in psychiatry based on sex differences. It attempts to explain why women are diagnosed and treated differently from men, and to investigate the nature of psychiatric practice, in this regard.

parts. First, an analysis of the data on diagnosis and treatment of mental illness, so called. Secondly, and analysis of three theories which attempt to account for the phenomenon of psychiatric social control, i.e. the medical model of mental illness, labelling theory and feminism. Finally, a theoretical framework is presented which attempts to avoid the inadequacies of the other theoretical approaches to the problem.

The fundamental argument in the thesis is that psychiatry acts to suppress those not directly involved in wage labour. It acts to redefine the social problems generated by capital as the indivudal problems of its victims.

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CHAPTER I

INTRODUCTION

In the mid nineteen-thirties, Frances Farmer was a film star who was just starting to conquer Hollywood. She was compared with Garbo and Hepburn and seemed destined for superstardom. However, when Frances Farmer died in 1970 of throat cancer, she died in obscurity. Between the period of her meteoric ascent in the nineteen-thirties and her death she had been exposed to the panoply of psychiatric technology: shock treatments, drugs and psychosurgery. From the end of her psychiatric treatment to 1970 Frances Farmer was an alcoholic with paranoid delusions and chronic memory loss. Her history has been subsequently expunged from the annals of Hollywood stardom.

Frances Farmer had been subjected to psychiatric processes which had as their object the wholesale

The material concerning Frances Farmer has been taken from Arnold W., Shadowland, New York, Jove Publications Inc., 1978.

alteration of her personality. The conventional question which arises from this history concerns the dynamics of Farmer's illness and the consequent treatment schemes. I prefer to pose another question: what are the dynamics of the psychiatric impulse to alter personalities? This study will not focus on the mechanisms of the disease which has purportedly invaded the subject's body and which manifests itself through the personality as symptoms. Instead the focus will be on the process whereby psychiatry observes some personalities as symptoms of underlying maladies.

The life history of Frances Farmer is to be the starting point, as it encapsulates all the areas of concern of this study. Frances Farmer was exceptionally bright. At sixteen years of age she won an award for writing an essay titled "God Dies". This event shocked the conservative Seattle community in which she lived and Frances gained a great amount of local notoriety. She was even denounced from pulpits as a victim of "Godless Communism". Frances was to go on to further outrage the local patriots, who had now formed an "American Vigilante" group. In 1935 she won a contest sponsored by the Communist

Party's newspaper, the "Voice of Action". Her prize was a visit to the Soviet Union, where she stood on the reviewing stand at May Day. On her return she stated

"I have never been definitely a Communist. My whole interest is in the theater. I'm an actress, or trying to be. But I came back more excited than ever about Russia, which is a marvellous place for any art. My sympathy and support are all for Russia."²

After this visit, Farmer made a number of Hollywood movies, and became a nationwide success. She maintained her radical opinions, demonstrated for migrant farm workers in California and formed the Group Theater in 1937. She starred in Clifford Odets' famous "proletarian" play "Golden Boy" and won "rave" notices.

It is arguable that the attempt to alter
Farmer's personality began in 1942 when she was
arrested for driving in a dimout zone with her lights
on. She was accused of being drunk after talking
contemptuously to the policeman and, without a breath

²Ibid., p. 43.

test or attorney was given an unusually harsh sentence of 180 days, suspended. At this time the first indications of "mental illness" crept into the papers. On a trip to Mexico City to shoot a film, Frances contracted "turista" commonly known as "Montezuma's revenge". However, this filtered back into the gossip column of Louella Parsons as a "breakdown".

Hollywood built the "breakdown" story into a tide of gossip which made Farmer's life in California difficult, culminating in a fight on a movie set after which assault charges were laid against her. Police officers broke into Farmer's hotel room and violently arrested her and jailed her overnight. In court, again without benefit of counsel, she was sentenced to 180 days in jail, not suspended.

At this point in the story, the police authorities moved aside to make way for the psychiatric authorities. A psychiatrist named Dr. Leonard, who had been following the case in the papers, decided that Frances Farmer was suffering from mental illness. He went to the Supreme Court and filed a complaint requesting that he be allowed to examine Frances as to her sanity. The result was a hearing in which Frances'

politics figured prominently. Although she was not declared legally insane, she was removed to a psychiatric ward where she received insulin shock treatment. The effects of the treatment were that

"(t)he walls and ceiling suddenly closed in on her and she passed out. When she regained consciousness, her body was trembling and drenched with perspiration. She felt, she told the doctors, "indescribably humiliated". She objected so strenuously that the dosage was increased."

For the next few months she was subjected to insulin two or three times per week. As a result she became frightened, lost much of her memory, was unable to read and could no longer write poetry. Her mother was upset by these treatments and arranged to have Frances released into her custody.

Frances was not quite the same person though, and her mother (presumably under the influence of various psychiatrists) arranged for Frances to be declared insane. The judge sitting on the case was a leader of the American Vigilante group and a lifelong opponent of Frances Farmer. He appointed an alcoholic

³<u>Ibid.</u>, p. 107.

defence counsel and Farmer's fate was sealed. She was committed to the Western Washington State Hospital at Steilacoom. Her "psychiatric report" noted the following symptoms: that she was vulgar, excited and arrogant. Her vulgarity was noted especially and the psychiatrists claimed that her vulgar words "embarrassed the staff". She was taken to Steilacoom in a strait-jacket.

Her first form of treatment at Steilacoom was Electro Convulsive Therapy, electroshock.

"Two attendants grabbed Frances and stretched her out in a prone position on a table in the center of the room. They attached electrodes to each of her temples and shoved a gag in her mouth. Then they stood back, turned on the electricity, and watched her body jump and twitch violently and uncontrollably until she passed out." 5

Frances gained a reputation for rebelliousness, even in the institution. She refused to admit that she had a mental problem (interpreted as a certain symptom of illness) and claimed that she was unjustly

⁴Ibid., p. 127.

⁵Ibid., p. 130-131.

incarcerated. This "anti-social" attitude was rewarded with massive doses of electroshock, and with hydrotherapy. The latter is a technique no longer used, in which the patient is submerged in ice water for six to eight hours. During one of those experiences Frances nearly bit off her lip. After months of treatment Frances became more docile and pliable, after which she was released as cured, "a significant victory for the mental hygiene movement" as one of her therapists said.

Nevertheless, Frances was closely watched.

She left her mother's house once and was found with migrant farmworkers and taken back home. Following this incident she was reported missing on two occasions, once when she went to a movie, and again when she visited some old friends. On her return from this second outing she was picked up by police and returned to Steilacoom. The doctors who had previously extolled their miraculous cures now claimed that Frances Farmer had merely been "acting normal" when she was docile and pliant, and obviously was in need of more treatment.

⁶Ibid., p. 132.

As a recidivist, Frances was placed in a "violent and hopelessly insane" ward which was described as follows:

"The floors in the entire lower section were bare dirt. In this single area a crowded conglomeration of psychopathic criminals, hopeless catatonics, senile old people, and mentally retarded children were herded together, living off cots spaced no more than a foot apart -- some chained to the cots, others curled up on the ground. There was no attempt at discipline or order in the ward. Food was thrown to the floor and the patients fought each other and the rats to get at it. Patients urinated and defecated and took sexual liberties with one another like caged animals..."7

Frances Farmer was repeatedly raped by orderlies, other patients, and gangs of soldiers who were brought in -- kickbacks for the staff. During this time, incredibly, Farmer never lost her rebelliousness and merely sharpened her resistance. Every time she refused to "work" cleaning up human waste and vomit from the ward floor she was shocked into insensibility. She remained uncooperative, apparently a beacon to the patients in the manner of a

⁷<u>Ibid.</u>, p. 141.

Ken Kesey hero. She was described by the psychiatrists using almost every term in the Index Medicus as paranoid, manic depressive, schizophrenic, catatonic, having a split personality, etc.

Clearly the shock treatments were not having results, at least not the desired results in terms of personality transformation. The next weapons in the psychiatric armoury, drugs, were brought into the theatre of conflict. Frances was given LSD and antidepressants. There were no records of the effects of these drugs, except inasmuch as they did not effect the radical alterations in Farmer which the doctors sought. The doctors prepared their trump card, psychosurgery.

Psychosurgery, in the early form of lobotomy, was just beginning its ascendancy in the United States in the nineteen-forties and fifties. The early form of prefrontal lobotomy which involved surgically opening the skull and destroying tissue in the frontal cerebral lobes had been modified in the U.S. by Dr. Walter Freeman. His operation was a transorbital lobotomy, which was effected by inserting an icepick-like instrument between the patient's eye and upper

eyelid and driving it through the orbital plate into
the brain. It was thought to be a procedure ideally
indicated for those with obsessive syndromes or
anxiety-tension states, especially people of high
intelligence, women, children and rebellious
adolescents. It was considered to have potential in
the treatment of schizophrenics, alcoholics, homosexuals,
radicals, habitual criminals and masturbators. The
great advantage of Dr. Freeman's refinement was that
now psychosurgery was quick and could be performed on
a mass scale. This would relieve the overcrowded
conditions of mental institutions following the post
war boom.

Freeman visited Steilacoom to perform "mass surgery" on a number of occasions. On his second visit he lobotomized thirteen women in a row, with an audience watching. As he worked he explained his technique:

"The patients for whom this operation brings the best results are those who are tortured with self-concern, who suffer from terribly painful disabling self-consciousness, whether it expresses itself in pains in the body organs or terrible distress from feelings of persecution ... In ordinary

language, the technique severs the nerves that deliver emotional power to ideas. Along with a cure comes some loss in the patient's imaginative power. But that's what we want to do. They are sick in their imaginations ..."8

Freeman examined Frances Farmer and, at the end of this visit Frances was taken to a remote treatment room, placed on a table and given electroshock until she passed out. Freeman then lifted her right eyelid and drove a probe into her brain. Following this operation Frances Farmer's personality did change. She was no longer rebellious, and was released in 1950.

Clearly the doctors had been intending to cure precisely that -- her rebelliousness. It is obvious that they were concerned about little else, for she was released with a host of symptoms of deep trauma which no doubt the doctors did not view as critical. Her intelligence was impaired, her creativity obliterated, her memory shredded. She tried to act, but could not memorize lines any more. She became alcoholic, zombie-like and subject to fits

^{8&}lt;u>Ibid.</u>, p. 161.

of paranoia. She died of cancer of the oesophagus in 1970 which could have been triggered by the drug therapy she had received a little over twenty years earlier. From 1950 until her death, Frances Farmer was never to be rebellious again.

In this thesis I intend to address the issues raised by the foregoing history of Frances Farmer.

The issues can be roughly divided into two categories.

First, the attitude of psychiatry to the female subject and second, the use of drastic behaviour modifying techniques on such subjects.

In this study I am addressing differential diagnosis and treatment in psychiatry based on sex differences. I shall attempt to explain why women are diagnosed and treated differently from men, and whether this tells us anything about the nature of psychiatric practice.

For this investigation, I have broken the thesis into three parts. First, an analysis of the data on diagnosis and treatment of mental illness, so called. Secondly, an analysis of the theories which attempt to account for the phenomenon of psychiatric social control, i.e. the medical model of mental illness,

labelling theory and feminism. Finally, I shall attempt to evolve a theoretical framework which avoids the inadequacies of the other theoretical approaches to the problem.

In the first section I will examine the available data on diagnostic categories and treatments. I shall be concerned with highlighting any sexual bias indicated by the data. Given the fact that certain diagnostic categories are deemed to require specific treatments, the issue becomes whether the categories themselves are objectively scientific, or subjective in nature and open to sex bias.

I shall examine the treatments themselves,
their indications, effectiveness, the extent of use,
etc. This is to discover whether the avowed aims of
treatment coincide with the actual results. As it is
my contention that the aims and results of treatment
do not coincide, I will argue that the actual results
of treatment reflect its unstated aims. To be precise,
I will try to show that the drastic psychiatric assaults
on the body do not achieve remission of disease
"symptoms", but quiet and control the patient. This
is in fact the intent of such treatment.

In the second section I shall examine three theories which attempt to comprehend the differential diagnosis and treatment of men and women by psychiatry. The first theory to be examined will be the traditional psychiatric viewpoint, the medical model of mental illness. This model upholds current methods of diagnosis and treatment based on a model analogizing mental distress and physical illness. The next two theories to be examined are attempts at radical critiques of traditional psychiatry. Labelling theory concentrates on the process of labelling a person "mentally ill" and the social reaction to this labelling, in which the individual in stigmatized and alienated from society. Feminist theory has confronted the problem of differential diagnosis and treatment in psychiatry and has isolated patriarchal culture as the key issue.

While both labelling and feminist theories
have a contribution to make in any critique of
psychiatry, I shall outline their respective
theoretical weaknesses. In the final section of the
thesis I shall present a theoretical framework which
roots psychiatric processes in the real processes of

social life. This framework will use the perspective of historical materialism.

In using this perspective, I shall present a brief introductory discussion of the materialist conception of the genesis of ideas. This is intended to lay the groundwork for an examination of the psychiatric social control of women.

Following this introduction I shall demonstrate that the psychiatric treatment of women operates in the interests of capital. I will discuss the oppression of women and psychiatry both as ideological and practical functions of capitalism.

In the discussion on women's oppression I shall outline the development of patriarchal relations in the bourgeois family and the role of class relations in this development. I will further discuss the relationship of women to the labour force and the role of patriarchal ideology in this relationship.

In the section on psychiatry I intend to discuss the relation of psychiatry to the historical development of the family. I will examine psychiatry's role as an institution of social control. To this end I shall consider the connection between psychiatry,

professionalism and the capitalist order.

My fundamental argument is that psychiatry acts to suppress those not directly involved in wage labour. It acts to redefine the social problems generated by capital as the individual problems of its victims.

CHAPTER II

DIAGNOSIS AND TREATMENT OF MENTAL ILLNESS

Introduction

The history of Frances Farmer is not an isolated experience. It is symptomatic of the general psychiatric approach to females. In this chapter I will present statistics on mental illness and hospitalization by diagnostic category. These demonstrate sex differentiation in psychiatric treatment: men and women are placed in different diagnostic categories.

The problems I will be addressing throughout this chapter are as follows. What is the nature of the diagnostic categories in which females tend to be largely represented? Are these categories clearly defined and scientifically verifiable? Do the treatments fit these categories? That is, do the treatments cure disease. alleviate symptoms or serve more obscure social functions? To synthesize these

questions: do the therapists have clear enough data on which to base their use of physical therapies such as electroconvulsive therapy, chemotherapy and psychosurgery? If not, is the use of such therapies conditioned by variables external to medical categories?

The data on the diagnosis and treatment of mental illness show that women appear in categories which are vaguely defined and require subjective diagnoses. Furthermore, based on this uncertain diagnosis, women receive drastic treatments. The treatments themselves have an uncertain outcome and are far from universally medically acceptable. This invites the question as to why therapists are willing to intervene with dangerous treatments on women who have been categorized with vague evidence as mentally ill?

Diagnostic Categories

The starting point in this consideration of psychiatric intervention in society is to ask who exactly comes under the scrutiny of psychiatrists?

The specific question is whether women in particular

come under psychiatric attention. Thus the problem is to find out whether women are more often mentally ill than men, or whether women are defined as such more often by therapists.

In the first place definitions of mental illness have changed greatly in the period from the turn of the century to the present. In the second place, methods of reporting the incidence of mental illness have also changed. These factors make it virtually impossible to record changes over time. However, it can be reasonably held that the growth of mass psychiatry really occurred in the post-World War Two period.

Dohrenwend and Dohrenwend found over eighty prevalence studies of mental illness in North America and Europe from the turn of the century to the present.

Many of the studies break down the material in terms of sex and diagnostic categories. As Table 1 indicates,

B.P. Dohrenwend and B.S. Dohrenwend, "Sex Differences and Psychiatric Disorders", American Journal of Sociology, Vol. 81, No. 6, May 1976.

most pre-1950 studies found the rate of psychopathology significantly higher for men than for women, and the post-1950 studies found the rates higher for women than for men.

TABLE 1

NUMBER OF EUROPEAN AND NORTH AMERICAN STUDIES REPORTING HIGHER RATES OF PSYCHIATRIC DISORDER FOR MEN OR FOR WOMEN ACCORDING TO PUBLICATION PRIOR TO 1950 OR IN 1950 OR LATER

| Date of Publication and Type of | Studies in Wh | nich Rate Is r for (N) |
|---------------------------------|---------------|---------------------------|
| Psychopathology | Males | Females |
| Before 1950: | | |
| All types | 7 | 2 |
| Psychosis | 3 | 3 |
| Neurosis | 1 | 2 |
| Personality disorder . | 3 | 0 |
| 1950 or later: | | |
| All types | 2 | 22 |
| Psychosis | 5 | 10 |
| Neurosis | 0 | 15 |
| Personality disorder . | 11 | 3 |
| | | |

Source: B.P. Dohrenwend and B.S. Dohrenwend, op.cit., p. 1448.

The rates for men did not surpass the rates for women in the categories of psychosis and neurosis

in the pre-1950 period. They only did so in the personality disorder category.

It appears as if overall rates of hospitalization and of rates for the major sub-categories of mental illness (psychosis, neurosis and personality disorder) have made a dramatic leap in the post-World War Two period. As can be seen in Table 2, the median overall rate prior to 1950 for both sexes was just under 2%, and this rate post-1950 has risen to over 15%.

One explanation for this jump has been that the definitions of diagnostic categories have significantly altered. This alteration occurred during and immediately following the war. Raines, in a 1952 Foreword to the <u>Diagnostic and Statistical Manual</u> of the American Psychiatrist Association wrote about patients seen during and immediately after the war, that:

TABLE 2

MEDIANS OF PERCENTAGES OF PSYCHIATRIC DISORDER REPORTED
FOR EUROPEAN AND NORTH AMERICAN STUDIES BEFORE 1950 AND
IN 1950 OR LATER

| _ | Before | 1950 | 1950 or | Later |
|-------------------------------|--------|---------|------------|---------|
| | Males | Females | Males | Females |
| Overall: Median Studies (N) | 1.89 | 1.91 | 15.4 22 | 23.5 |
| Psychosis: Median Studies (N) | 0.445 | 0.43 | .120 | 1.69 |
| Neurosis: Median Studies (N) | 0.20 | 0.26 | 3.56 15 | 8.0 |
| Personality disorder: Median | 0.63 | 0.12 | 5.85 13 | 2.94 |

Source: B.P. Dohrenwend and B.S. Dohrenwend, op.cit., p. 1450.

"Only about 10% of the total cases fell into any of the categories ordinarily seen in mental hospitals. Military psychiatrists, induction station psychiatrists, and Veterans Administration psychiatrists, found themselves operating within the limits of a nomenclature specifically not designed for 90% of the cases handled."²

This accounts for some of the expansion in mental illness classifications. Presumbably the unnamed 90% of cases needed naming. There were however, deeper social influences which led to the development of mass psychiatry.

The field itself refined and narrowed its definitions. Schizophrenia now had a number of subspecies, for example in 1949 giving birth to "pseudoneurotic schizophrenia". Most significantly a movement was afoot to broaden public consciousness of mental health issues, the mental hygiene or mental health education movement. This movement was at its peak in the nineteen-fifties and 'sixties. One of its consequences could have been an increase in public use

²<u>Ibid.</u>, p. 1450.

³ Ibid.

of psych iatric facilities, and conversely, the psychiatric profession probably felt less reluctant to tout for business. Psychiatry was becoming acceptable.

The expansion of the concepts of mental illness accounts for some of the growth in rates of mental illness post-World War Two. However, it does not account for the disproportionate jump in female rates. As can be seen in Table 3, the male median overall rate of psychiatric disorder moved from 2% to 15% after 1950, whereas the female median overall rate soared from 2% to 24%! In fact, if the differences are followed through to 1960 and later, the female rates maintain a clear lead at 27%, with the male rate moving to 18%.

Apart from the fact that the changes in the psychiatric image of mental illness have been so sweeping, the differences in methods of reporting over time further complicate the picture. In the pre 1950 studies, 4 the investigators relied on key

⁴B.P. Dohrenwend, and B.S. Dohrenwend, "Social and Cultural Influences on Psychopathology", <u>Annual</u> Review of Psychology 25, 1974.

informants and official records (records with police and other agents of social control) to identify potential cases. This procedure identified the most visible "mentally ill" personalities, alcoholics, criminals, etc. These categories tend to be disproportionately male. The private categories of neurosis and to a lesser extent manic-depressive psychosis would resist inclusion in the overall picture of mental disorder. These categories, as will be demonstrated later are overwhelmingly female. 5

After 1950 the investigators used different techniques, relying for the most part on direct interviews with respondents. In the nineteen sixties screening inventories were developed by researchers such as Langner. These inventories focus on symptoms of anxiety, depression and physiological disturbances associated with neurotic disorders and manic-depression.

⁵M. Mazer, "People in Predicament: A Study in Psychiatric and Psychosocial Epidemiology," <u>Social</u> Psychiatry 9 (July), 1974.

⁶T.S. Langner, "A Twenty-two Item Screening Score of Psychiatric Symptoms Indicating Impairment", Journal of Health and Social Behavior 3 (Winter), 1962.

TABLE 3

MEDIANS OF OVERALL PERCENTAGES OF PSYCHIATRIC DISORDER REPORTED FOR EUROPEAN AND NORTH AMERICAN STUDIES, BY DATE OF PUBLICATION

| | BEFO | ORE 1950 | 1950 | 0-59 | 1960 OR LATER | | | |
|-----------------------|-------|----------|-----------|---------|---------------|-------------|--|--|
| | Males | Females | Males | Females | Males | Females | | |
| Median Studies (N) | | | 12.1 6 | 13.6 | | 26.75 16 | | |

Source: B.P. Dohrenwend and B.S. Dohrenwend, op.cit., p. 1451.

Using such inventories women score much higher rates than men.

The Dohrenwends summarize their "study of studies" findings as follows:

- "(1) There are no consistent sex differences in rates of functional psychoses in general (34 studies) or one of two major subtypes, schizophrenia (26 studies), in particular; rates of the other subtype, manic-depressive psychosis, are generally higher among women (18 out of 24 studies).
- (2) Rates of neurosis are consistently higher for women regardless of time and place (28 out of 32 studies).
- (3) By contrast, rates of personality disorder are consistently higher for men regardless of time and place (22 out of 26 studies).

Thus, while it is difficult to map out overall trends over time due to methodological problems, some factors are relatively certain. In the first place there is a trend to define more people in general, (and possibly more women in particular) as mentally ill. Also, more women than men appear in categories which have no direct physical causation, such as

⁷B.P. Dohrenwend and B.S. Dohrenwend, op.cit., 1976, p. 1453.

neurosis, whereas men appear predominantly in categories such as alcoholism which do have a direct material cause (alcohol). This last point will become clearer in a breakdown of Canadian statistics on the hospitalization of mental illness.

Probably the best way to explore the problem of sex differentiation in diagnostic classification is to review the Federal Statistics on mental institutions and analyse them in terms of sex and "illness category". These show that more men than women appear to be among the first admissions to mental institutions. Thus, if there are differences in the psychiatric treatment of males and females, they should be found in terms of the reasons why people are under psychiatric scrutiny. That is, do men and women enter psychiatric care under different labels: If this is so, what is the significance of this finding?

The data available in Statistics Canada's

Statistics Canada, <u>Mental Health Statistics</u> - 1974. Vol. No. 1, "Institutional Admissions and Separations", Catalogue 83-204, Annual, November, 1976.

^{9&}lt;sub>Ibid</sub>.

"Mental Health Statistics - 1974" 10 is based solely on inpatient events and excludes those patients being treated for mental disorders in out-patient facilities, day and night centres, non-psychiatric wards of general hospitals, half-way houses, and offices of private practitioners. Statistics for first admissions are subject to error; for instance, some provincial hospitals classify "first admissions" as those patients admitted to their particular hospitals for the first time (regardless of any previous history of inpatient care in facilities outside their system). Further, some inpatient psychiatric facilities may not report for a given year. Therefore, it should be noted that the first admission statistics published in "Mental Health Statistics - 1974" are not to be considered as indices of incidence of mental disorders.

Taking the above factors into consideration

I will now examine statistics concerning first

admissions into psychiatric inpatient facilities

¹⁰ Ibid.

across Canada in 1974. 11 The data concerning patient populations are broken down into detailed diagnostic classes by sex as follows. Out of a total of 60,131 first admissions in all reporting institutions in 1974, 52% were male and 48% were female. As can be seen in Table 4, the most frequent diagnosis for males was alcoholism which accounted for 25% of all male first admissions. This was followed by neuroses (19%), schizophrenia (11%) and personality disorders (8%). For females the predominant diagnoses were neuroses (40%), schizophrenia (9%) affective psychosis (11%) and personality disorders (6%).

This distribution according to diagnostic class has been a pattern for both males and females for several years.

"A pattern which has persisted over time is the tendency for certain diagnoses to be sex related. For example, first admissions for

llbid. It must be borne in mind that the first set of statistics is based on the 333 reporting facilities which include public mental hospitals, public psychiatric units, institutions for the mentally retarded, psychiatric hospitals, aged and senile homes, federal psychiatric units, hospitals for addicts, treatment centres for emotionally disturbed children and epilepsy hospitals.

| Selected Diagnostic | WOMEN | | MEN | | |
|--|--------|---------|--------|---------|--|
| Classes | Number | Percent | Number | Percent | |
| ALL DIAGNOSES - TOTAL | 28,789 | 48 | 31,342 | 52 | |
| PSYCHOSES | | | | | |
| Alcoholic Psychoses | 172 | 0.5 | 647 | 2 | |
| Schizophrenia | 2,650 | 9 | 3,363 | 11 | |
| Affective Psychoses | 3,218 | 11 | 1,919 | 6 | |
| Parnoid States | 480 | 1.6 | 411 | 1.4 | |
| Other and Unspecified | 1,121 | 4 | 924 | 3 | |
| NEUROSES, Personality disorders, and other non-psychotic disorders | | | | | |
| Neuroses | 11,580 | 40 | 5,821 | 19 | |
| Personality Disorders | 1,757 | 6 | 2,493 | 8 | |
| Sexual Deviation | 4 | 0.01 | 53 | 0.5 | |
| Alocholism | 1,453 | 5 | 7,903 | 25 | |
| Drug Dependence | 453 | 1.6 | 751 | 2 | |
| Physical disorders of presumably | | | | | |
| psychogenic origin | 62 | 0.2 | 46 | 0.2 | |
| Special Symptoms not elsewhere | | | | | |
| classified | 127 | 0.4 | 114 | 0.3 | |
| Transient situational disturbances | 1,629 | 6 | 1,220 | 4 | |

^{*} All diagnostic categories excluding organic, senile dementias and diseases of childhood.

Source: Based on Statistics Canada, op. cit., Table 4, p. 56.

alcoholism and alcoholic psychosis had a very high preponderance of males, whereas first admissions for affective psychoses and neuroses had a high proportion of females."12

The two largest mental hospital systems in Canada are public mental hospitals (PMH) and public psychiatric units (PPU). These hospitals make up 48% of the total number of reporting psychiatric institutions in Canada. The importance of these two institutions is demonstrated by the fact that together they account for 72% of the total first admissions to mental institutions. Out of the total first admissions in PMHs and PPUs, 70% are in PPUs.

Compared with other types of psychiatric inpatient facilities, PMHs receive a greater relative
proportion of first admissions in the "psychoses"
class with diagnoses of senile and presentle dementia,
alcoholic psychoses and psychoses associated with
physical conditions. As indicated in Table 5, males
make up the highest proportion of first admissions at
62%. The most common diagnosis of all first admissions

¹² <u>Ibid.</u>, p. 13.

TABLE 5

PUBLIC MENTAL HOSPITALS, FIRST ADMISSIONS, 1974, DIAGNOSTIC CLASS*, BY SEX, AGES 15-59.

| and the second s | | | | | Torque de la constitución de la | |
|--|--------------------------------|-------------------------------|------------------------------------|--------------------------------|---|-----------------|
| Selected Diagnostic | WOM | EN | ME | N | TOTAL | ADMISSIONS |
| Classes | Number | Percent | Number | Percent | Number | Percent |
| ALL DIAGNOSES - TOTAL | 4,831 | 38 | 8,030 | 62 | 12,861 | 100 |
| PSYCHOSES | | | | | | |
| Alocholic Psychoses Schizophrenia Affective Psychoses Paranoid States Other and Unspecified | 51 693 453 124 198 | 17.5 36 54 50 46 | 242 1,228 381 126 234 | 82.5 64 46 50 54 | 293 1,921 834 250 432 | 6.5 |
| NEUROSES, Personality disorders, and other non- psychotic disorders | - | | | | | |
| Neuroses Personality Disorders Sexual Deviation Alcoholism Drug Dependence | 1,188 440 1 320 81 | 61 29.5 5 13.5 30 | 772 1,056 18 2,059 187 | 39 70.5 95 86.5 70 | 1,960 1,496 19 2,379 268 | 12 0.1 18 |
| Physical disorders of presumably psychogenic orions Special Symptoms not | | 25 | 9 | 75 | 12 | 0.1 |
| elsewhere classified Transient situational | 6 | 60 | 4 | 40 | 10 | 0.1 |
| disturbances | 361 | 48 | 393 | 52 | 754 | 6 |

^{*} All diagnostic categories excluding organic, senile dementias and diseases of childhood.

Source: Based on Statistics Canada, op. cit., Table 45, p. 166.

was alcoholism (18%), followed by neuroses (15%), schizophrenia (15%), personality disorders (12%), and affective psychoses (6%). Of all those diagnosed as alcoholic 86.5% were male, similarily 70.5% of personality disorders and 64% of schizophrenics were male. Of all those diagnosed as neurotic, 61% were female.

PPUs accounted for 51% of the total of the first admissions to all institutions combined. PPUs differ from PMHs in the fact that PPUs focus more upon providing short-term intensive treatment and care. This is reflected in the statistics which show a greater proportion of admissions in the "neuroses" category as compared to the "psychoses" category. As the data in Table 6 indicate, neurosis was the most predominant diagnosis, representing 43% of the total first admissions. This was followed by affective psychoses (12%), schizophrenia (10%), personality disorders (6%) and alcoholism (6%). Females account for 59% of first admissions, yet comprise 68% of those diagnosed as neurotic in PPUs. (Almost one half of female first admissions are diagnosed as neurotics.)

TABLE 6

PUBLIC PSYCHIATRIC UNITS, FIRST ADMISSIONS, 1974, DIAGNOSTIC CLASS*, BY SEX, AGES 15-59.

| Selected Diagnostic | WOMEN | | MEN | | TOTAL ADMISSIONS | |
|--|------------------------------------|------------------------------|-------------------------------------|------------------------------|--|-----------------------------|
| Classes | Number | Percent | Number | Percent | Number | Percent |
| ALL DIAGNOSES - TOTAL PSYCHOSES | 18,140 | 59 | 12,418 | 41 | 30,558 | 100 |
| Alcoholic Psychoses Schizophrenia Affective Psychoses Paranoid States Other and Unspecified | 97 1,569 2,389 292 780 | 24 50.5 65 56 58 | 301 1,543 1,272 227 564 | 76 49.5 35 44 42 | 398 3,112 3,661 519 1,344 | 1 10 12 2 4 |
| NEUROSES, Personality disorders, and other non- psychotic disorders | | | | | | |
| Neuroses Personality Disorders Sexual Deviation Alcoholism Drug Dependence Physical disorders of pro- | 9,017 1,005 1 389 183 | 68 52 5 22 43 | 4,177 921 19 1,358 240 | 32 48 95 78 57 | 13, 194 1,926 20 1,747 423 | 43 6 0.06 6 0.1 |
| Physical disorders of pre- sumably psychogenic origin Special Symptoms not elsewhere classified | 55 91 | 64 68 | 31 43 | 36 32 | 86 134 | 0.3 |
| Transient situational disturbances | 878 | 65 | 479 | 35 | 1,357 | 4 |

^{*} All diagnostic categories excluding organic, senile dementias and diseases of childhood.

Source: Based on Statistics Canada, op. cit., Table 63, 0.208.

At first glance it appears that the proportion of male to female first admissions is roughly even in both PPUs and PMHs populations combined (52% female, 48% male). Therefore as we have seen, after examining diagnostic classifications a high degree of sexual differentiation/discrimination is evident. Whereas males were admitted for the most part with tangible syndromes associated with physical symptomatology (alcoholism, alcoholic psychoses, and psychoses associated with intracranial infection and other cerebral and physical conditions), females were admitted overwhelmingly with neuroses.

As indicated in Statistics Canada 32% of male first admissions are neurotics, while neurosis accounts for 68% of female first admissions. 13 Neurosis is a condition with no unitary definition and it is apparent that psychiatrists whose categories appear as statistical absolutes in Statistics Canada each have different views of their creation. Gove and Tudor attempt to synthesize a definition for neurosis as

¹³ Statistics Canada, op. cit.

"anxiety in the absence of psychotic disorganization". 14
Psychotherapist Hans H. Strupp defines neurosis/
psychoneurosis as follows:

"A psychological disorder often characterized by (1) sensory, motor, or visceral disturbances, (2) anxiety, (3) troublesome thoughts, (4) sleep disturbances, (5) sexual disturbances, (6) general inhibition. Reality contact remains similar to that of the community." 15

Both definitions above and indeed all definitions of neurosis are so vague and malleable as to allow almost any interpretation.

It can be demonstrated from the foregoing data that males and females receive differential attention from psychiatry. Women are overwhelmingly classified in categories, such as neurosis, which have no physiological foundation. Men are classified in categories which do have organic or toxic etiologies,

¹⁴W.R. Gove, and J.F. Tudor, "Adult Sex Roles and Mental Illness", in J. Huber ed., Changing Women in a Changing Society, Chicago, U. of C. Press, 1973, p. 50.

¹⁵H.H. Strupp, <u>Psychotherapy and the Modification of Abnormal Behavior</u>, New York, McGraw Hill, 1971, p. 190.

such as alcoholic psychoses. This infers that practitioners exercise a greater degree of diagnostic discretion with regards to females than with males.

As has been argued the definitions of neurosis are vague and uncertain, inviting the practitioner to base his diagnoses on subjective criteria. Given this threshold of uncertainty, the question becomes whether women are differentially treated by psychiatrists.

Treatment

In the following section I will examine the therapies which women are subject to after being diagnosed as neurotic, depressive, etc. I will concentrate on the physical methods of therapeutic intervention: electro-convulsive therapy, chemotherapy and psychosurgery. These are drastic and often irreversible therapies. They are recommended treatments for neuroses and are most often used on women. In the sections on each therapy I shall consider the nature of the treatment, the target groups in terms of diagnostic and sex category, the effects and side effects of treatment, success rates, etc. Thus a comparison may be made between the

practitioners' claims for the efficacy of the treatment and the actual results. These data suggest that the treatments are devastating responses to marginal medical evidence of "illness". Moreover, the effects of treatment are often more damaging than the original "sickness".

a. Electroconvulsive Therapy

therapies, shock treatment by means of injection of chemicals producing convulsions was in widespread use. This technique began with Meduna in fascist Hungary in 1934. Meduna used intramuscular injections of camphor to induce convulsions in schizophrenic patients. This technique was abandoned after the introduction of the more sophisticated electrical technologies. The father of modern electroconvulsive therapy is said to be Ugo Cerletti, who invented the technique in 1938 in Mussolini's Italy. Cerletti

Arthur P. Noyes, Modern Clinical Psychiatry, 3rd Edition, Philadelphia, W.B. Saunders, 1949.

¹⁷ Ibid.

postulated that the stress of shock treatment produced beneficial humours or "acragonines" which combatted mental illness. He thought that the technique should be used on schizophrenics.

The most common ECT technique now employed is Bilateral ECT where electrodes are applied to a patient's temples. Voltages administered range from seventy to one hundred and fifty volts, with a current of up to one amp. The current is applied for 1/2 second to 1 second. There follows a grand mal epileptic convulsion; which consists of a cessation of respiration, alternate stiffening and shaking. The treatment is recommended for

"symptoms associated with the depressed phase of manic-depressive illness or involutional melancholia." 18

Between six and twelve treatments are recommended for depressives and eighteen to twenty-five for schizophrenics.

Its enthusiasts have grandiose claims for ECT.

Peck (a eugenicist) in a book with the triumphal title

^{18 &}quot;Electro-convulsive Therapy in Massachussetts, a task force report", Mass. of Mental Health, Vol. 4: Winter 1973, pp. 3-29.

"The Miracle of Shock Treatment" views ECT as a panacea. "Surely shock treatment represents one of those medical miracles that Reader's Digest likes to write about". 19 Peck states unequivocally that it cures not only depression (endogenous or reactive) but also schizophrenia (all varieties), mania, agitation, agitation in terminal illness, insomnia, psychosis, ulcers, colitis, asthma, psoriasis, drug withdrawal and backaches! Peck sees no contraindications and recommends shock even for pregnant women and heart patients. This is in line with the views of Lothar Kalinowski, a leading proponent of ECT:

"ECT is not dangerous in the first months of mother or child, nor does it accelerate the termination of pregnancy. It may also be mentioned that age is no contraindication to ECT; both young children and very old persons can be treated."²⁰

Peck uses shock largely on depressives and neurotics, defining depression as "a sad, melancholy," blue" mood accompanied by a feeling of hopelessness

¹⁹ R.E. Peck, The Miracle of Shock Treatment, Jericho Press, N.Y., 1974, p. 13.

²⁰Alfred M. Freeman & Harold I. Kaplan, Comprehensive Textbook of Psychiatry, Baltimore Williams and Wilkins, 1967, p. 1282.

and extreme pessimism". 21 Peck does not clearly separate neurosis from depression, and "depression" is subsumed under the categories of neurosis.

Who receives shock? It is a technique used on depressives and neurotics. As was shown in the previous chapter, most people in these categories are female. Therefore it follows that more women than men would be likely to receive ECT. Most studies indicate that this is precisely the case. 22 In fifteen case studies cited by Peck, ten involve female subjects. 23

Paula Fine, who wrote a study titled "Women and Shock Treatment" records a number of such cases. 24

For example, one woman was admitted suffering from depression following her husband's attempted suicide and his daily threats to repeat the attempt. She was treated with shock for this reaction to her suicidal

²¹ R.E. Peck, <u>op.cit.</u>, p. 67.

²²P. Chesler, <u>Women and Madness</u>, N.Y., Avon Books, 1972.

²³ R.E. Peck, op.cit.

²⁴P. Fine, "Women and shock treatment", <u>Issues</u> in <u>Radical Therapy</u>, Vol. 2, Summer 1974, pp. 9-11.

reality testing (presumably to get the patient to recognize the concrete source of her problems), the doctor replied that "women aren't ready to hear the truth". One woman was admitted for hitting her husband after having been physically abused by him and by her father for years previously. She was treated with shock. One psychiatrist administered shock to a ten year old girl after some pre-pubescent sex play with a girl friend. 25 Paula Fine was unable to find records beyond the previous six months in the hospital where she conducted her study. However, she produced the following table of shock treatments by the month:

"July - 10 people, 9 were women

Aug. - 16 people, 14 women

Sept. - 14 people, 13 women

Oct. - 14 people, 10 women

Nov. - 11 people, 7 women

Dec. - 7 people, 5 women."²⁶

P. Chesler, <u>Women and Madness</u>, op. cit., p. 193.

²⁶ P. Fine, op.cit., pp. 9-11.

In Canada in 1972, three times as many women as men received shock treatment. 27 For inpatients in non-mental hospitals alone, in 1976, 889 males and 1,850 females received shock treatment. 27b In Ontario in the five years up to 1978, a total of 156,163 shock treatments were administered. 27c Don Weitz, in an article titled "The Shock of Your Life" estimates that every year 10,000 Canadians receive 100,000 shock treatments. 27d

Women commonly suffer amenorrhea as a sequel to ECT. Pregnant rats have been shown to spontaneously abort if ECT is given within fifteen hours of insemination. Yet Kalinowski recommends ECT even for pregnant women. 28

²⁷ Statistics Canada, Mental Health Statistics, Vol. 1, Institutional Admissions and Separations, 1972, p. 148.

²⁷bStatistics Canada, Surgical procedures and treatments, Catalogue 82-208, 1976, p. 162.

²⁷cDon Weitz, "The Shock of Your Life", Canadian Weekend, Dec. 8, 1979, p. 10-13.

²⁷d Ibid.

²⁸ Stanley T. Michael, "The Menstrual Cycle and Recovery during Shock Treatment", Diseases of the Nervous System, Vol. 15, 1954, and P. Fine, op.cit.

Does shock work on its own terms? Are the "symptoms" of "disease" alleviated? One study tested forty-one patients before and after ECT, and a matched group of twenty-six without ECT. 29 There was no significant difference in the rate of improvement between the two groups.

Another study tested matched groups subjected to Regressive Electroshock Therapy (REST), drug and group therapies. REST consists of multiple shocks in rapid succession on the same day (also called multiple ECT). This reduces patients to a pre-infantile state of incontinence, aphasia and stupor. The study found that six months after REST treatment, patients scored significantly lower on rating scores than they did prior to treatment. It has been shown

²⁹ Isidor W. Scherer, "Prognoses and Psychological Scores in Electroconvulsive Therapy, Psychosurgery and Spontaneous Remission," American Journal of Psychiatry, Vol. 107, 1951.

³⁰ Peter D. King, "Regressive EST, Chlorpromazine and Group Therapy in Treatment of Hospitalized Chronic Schizophrenics," American Journal of Psychiatry, Vol. 115, 1958.

that ECT has no effect on schizophrenia 31, and that among the elderly it accelerates the onset of senile brain dysfunction. 32

The most consistent effect of shock treatment is memory loss. This is a devastating effect. One woman who had received twenty one ECT treatments couldn't find her way around the town in which she lived, could hardly find her own home and could no longer sew and knit. 33 Another woman, twenty four years old, after having fifteen shock treatments mentioned looking through her journal which she had kept for some years, and finding nothing familiar in it. 34

Dr. Friedberg interviewed an ex-patient who

³¹ Sol Levy and R.H. Southcombe, "Value of Convulsive Therapy in Juvenile Schizophrenia", Archives of Neurology and Psychiatry, Vol. 65, 1951.

³² John S. Hamlon and Stuart Atkinson, "Electroconvulsive Therapy, A Controlled Study of its Effects in Geriatric Patients", Geriatrica, Vol. 11, 1956.

³³J. Friedberg, Shock Treatment is not good for your Brain, San Francisco, Glide Publications, 1976, p. 14.

³⁴Cited in <u>Ibid</u>.

couldn't remember why she had gone into therapy. The shock treatments had left her with two years of memory loss, retrograde amnesia, covering the period prior to (but not including) her hospitalization. 35

In 1950, Irving Janis studied the effects of ECT on memory and found that among his subjects, "(a)11 of the ECT patients, as of approximately four weeks following the termination of treatment, exhibited clear-cut instances of retroactive amnesia..."

Studies on Electroconvulsion Therapy reviewed five hundred papers on the subject from 1959 to 1963.

Every single paper detailed impairment of learning ability.

The effects of ECT on memory are probably the result of the infliction of irreversible brain damage by electric shock. A 1972 study 38 by Gonmer, Goldman and Templer of patients who had received ECT ten to

³⁵J. Friedberg, op.cit., p. 14.

Irving L. Janis, "Physiologic Effects of Electric Convulsive Treatments", <u>Journal of Nervous</u> and <u>Mental Disease</u>, Vol. III, May 1950, p. 359.

Cited in J. Friedberg, op.cit.

³⁸ Ibid.

fifteen years previously concluded that dramatic deficits in learning ability were present and that "ECT causes irreversible brain damage". Soviet therapists are far less equivocal about the brain damaging effect of ECT than their Western counterparts. Portnov and Fedotov in the Russian standard text "Psychiatry" explain that ECT "involves gross interference in bodily functions, and entails pinpoint hemorrhages in the brain tissue".

Despite the fact that Kalinowski and Peck find that ECT is suitable even for heart patients (above) it has been demonstrated that ECT stress on a diseased heart may be excessive. Many ECT deaths have resulted from cardiovascular collapse, myocardial infarction, and even myocardial rupture. 40

Most therapists do not accept the finding that irrepairable brain damage is caused by ECT. Acceptance of the existence of shock-induced cerebral damage

Anatoly Portnov and Dmitry Fedotov, Psychiatry, Moscow, Mir Pubs., 1969, p. 1410.

⁴⁰N. Malamud and A. Zheutlin, "Fatal Cardiac Complications during Electroshock Treatment", <u>Journal of Nervous and Mental Disease</u>, Vol. 117, May 1953.

would leave the thesis of the equation of mental illness with brain damage open to question. Why further damage the brains of those already purportedly suffering from brain damage? However, the therapists' arguments against the existence of irreversible brain damage resulting from shock tend to take the form of simple denials, rather than scientific deductions.

Kalinowski merely asserts that ECT is "not dangerous". However, in a 1974 interview, the head of

Neuropsychology at Stanford University stated, "I'd rather have a small lobotomy than a series of electroconvulsive shock ... I just know what the brain looks like after a series of shock—and it's not very pleasant to look at."

This problem has led some proponents of ECT to postulate that brain damage is therapeutic.

"Is a certain amount of brain damage not necessary in this type of treatment? Frontal lobotomy indicates that improvement take place by a definite damage of certain parts of the brain."42

⁴¹ Quoted in American Association Monitor Sept./Oct., 1974.

⁴² Paul H. Hock, M.D., "Discussion and Concluding Remarks Round Table on ECT", Journal of Personality, Vol. 17, 1948, p. 48.

Studies with "neurotic" animals led Masserman to state that

"...these experiments supported the growing convinction among psychiatrists that electroshock and other drastic procedures, though possibly useful in certain relatively recent and acute psychoses, produce cerebral damage which charges the indiscriminate use of such "therapies" with potential tragedy."43

Thus far it appears as if ECT is a therapy used mainly on women defined as neurotics. Yet not only is this definition in itself problematic, the treatment is also questionable. It is a drastic therapy leading to possible brain damage and crippling side effects. Even on its own terms ECT has minimal success. Before asking why this dangerous and dubious technique is used so frequently, let us examine the other physical therapies, chemotherapy and psychosurgery.

b. Chemotherapy

Drug therapy is so widespread in fact that it is difficult to believe that it is a phenomenon of

⁴³ Jules Masserman, M.D., "Experimental Neuroses", Scientific American, March 1950, p. 249.

relatively recent vintage. Drug prescription for mental illness really began to come into vogue in the early 1950's with the synthesis of chlorpromazine in 1951. The "minor tranquilizers" which were to gain such great popularity were introduced with the production of Meprobamate (Miltown or Equanil) in 1954. Librium was the next drug to arrive, patented by Roche pharmaceuticals in 1960. The inventor of Librium, Leo Sternbach, went on to produce the widely used drug Diazepam, or Valium, in 1963.44

The "Psychotropic" description of the drug may be defined as follows:

"The term 'psychotropic' may be applied to any drug which affects the brain, producing an alteration in mood, consciousness, or other psychological or behavioral functions. Most doctors in the United Kingdom restrict the term to five groups of drugs which appear in the drug classification of the Department of Health and Social Security. These are barbiturate hypnotics, non-barbiturate hypnotics, tranquillizers, anti-depressants, and stimulant and

⁴⁴E. Drobot, "Mother's Little Helper",
Weekend Magazine, Sept. 23, 1978, pp. 14-16.

appetite suppressants. The tranquillizer group includes "minor" tranquillizers used mainly to treat anxiety and tension in patients labelled as suffering from psychoneuroses."

to the present, the rise in the production and prescription of psychoactive drugs has been nothing short of spectacular. In the U.S. the increase in use of Valium and Librium in particular has been phenomenal. Within nine years of its introduction, Valium became the most frequently prescribed drug in North America. In the U.S., by 1972 Valium was selling 50 million annual prescriptions. Within twelve years of its introduction, Librium became the third most frequently prescribed drug in North America. In the U.S., by 1972 Librium sold 20 million prescriptions annually.

P.A. Parish, "The Family Doctor's Role in Psychotropic Drug Use" in R. Cooperstock, Social Aspects of the Medical Use of Psychotropic Drugs, Toronto, Alcoholism and Drug Addiction Research Foundation of Ontario, 1974, p. 75.

⁴⁶ I. Waldron, "Increased Prescribing of Valium, Librium, and Other Drugs - An Example of the Influence of Economic and Social Factors on the Practice of Medicine", International Journal of Health Services, Vol. 7, No. 1, 1977, pp. 37-62.

In 1974 3 billion tablets of Valium and 1 billion tablets of Librium were sold, enough for one week of drug therapy for every person in the U.S.

One in ten U.S. adults uses Valium or Librium for periods from a few weeks to a few months. 47 By 1976,

U.S. sales of minor tranquilizers amounted to \$520 million. 48 Valium tops the list of drugs bought in Ontario through the Drug Benefit Plan (paying for drugs prescribed to the elderly and to welfare recipients). In October, 1977, 2,755,741 tablets of Valium were dispersed through this Plan alone. In Saskatchewan which has a similar drug plan the picture is similar, Valium being the most commonly prescribed drug there also. 49

In Canada and the United States minor tranquilizers rose from being 22.7% of the market in psychotropic drugs in 1965 to 36.2% in 1971. In 1971

⁴⁷ Ibid.

[&]quot;Lengthy use of anti-anxiety drugs ineffective, U.S. reminds doctors", Globe and Mail, Jan. 10, 1978, p. 11.

J. Doig, "The High Cost of Tranquillity", The Canadian, July 22, 1978, pp. 3-5.

all tranquilizers and anti-depressants represented 58.5% of the market. ⁵⁰ In the U.K. from 1965-1971 the total number of prescriptions increased from 244.3 million to 266.5 million. However, for psychotropic drugs the increase was from 38.5 million to 48.0 million over the same period. For tranquilizers, prescriptions rose from 10.8 million in 1965 to 17.2 million in 1970. ⁵¹ (An increase of almost 70%.)

The question remains as to who receives drugs.

All groups of people are now prescribed drugs. (This includes children who used to be punished for being "naughty" or "restless". They are no longer just physically disciplined, they are now tranquilized.)

As we shall see in detail, these drugs are most commonly prescribed for simple states of anxiety or depression, and the majority of them go to women. 52

R. Cooperstock, "Some Factors Involved in the Increased Prescribing of Psychotropic Drugs", in R. Cooperstock, op.cit., p. 24.

⁵¹ Ibid.

⁵² Ibid.

"As with opiates in the 19th century, so with psychotropics in recent decades: women are 2 to 3 times more likly than men to have such prescriptions written." 53

The data on women and psychotropic drug use suggests the following. Women are perceived as visiting doctors with ill-defined complaints such as anxiety, for which they receive non-specific medicine, i.e. tranquilizers. Females receive more prescriptions than males, but the most dramatic difference is in the prescription of tranquilizers. The female usage of tranquilizers is likely to be more frequent and steady. The frequency of drug use increases with age, and for women the peak use is in the middle years. Furthermore, drug use is correlated with work status. Finally, doctors are more likely to offer tranquilizers to women than to men presenting the same complaints. 54

S. Wolfe, "The Social Responsibility of the Physician in Prescribing Mind-Affecting Drugs", in R. Cooperstock, op.cit., p. 56.

R. Cooperstock, "A Review of Women's Psychotropic Drug Use", Can. J. Psychiatry, Vol. 24, 1979, p. 31.

Females receive more prescriptions for psychotropics than males. ⁵⁵ In Saskatchewan, ⁵⁶ for example, reports are 62.9% for females against 37.9% for males. It has been repeatedly shown that between 67% and 72% of all psychotropics go to women. ⁵⁷ In the U.K. women consume twice as much tranquilizers and antidepressants as man do. ⁵⁸ As can be seen in Table 7, three figures hold true that only for Canada and U.K., but also for the U.S., Sweden, Spain, Italy, Netherlands, West Germany, France, Denmark and Belgium. This consistency is quite remarkable, with the international mean rate giving females almost twice as many tranquilizing drugs as males.

Dr. Ian Henderson, chairman of the Canadian Medical Association, estimated that in 1976 20% of

⁵⁵Ibid., pp. 29-34.

⁵⁶ Saskatchewan Department of Health, Saskatchewan Prescription Drug Plan, Annual Report, 1975-1976.

M. Balter, J. Levine and D. Manheimer, "Crossnational study of the extent of anti-anxiety sedative drug use", N. Engl. J. Med., 290, 1974, pp. 769-74, and R. Cooperstock, "Psychotropic drug use among women", Can. Med. Assoc. J., 115, 1976, pp. 760-763.

⁵⁸D. Skegg, R. Doll, J. Perry, "Use of medicines in general practice", <u>Br. Med. J.</u>, 1977, pp. 1561-63.

TABLE 7

INTERNATIONAL USE OF ANTI-ANXIETY SEDATIVE MEDICINES
IN 1971

| | Male % | Female % |
|-------------|-----------|-------------|
| | | |
| Belgium | 12.0 | 20.9 |
| Denmark | 10.2 | 19.9 |
| France | 11.9 | 21.4 |
| W. Germany | 8.4 | 19.2 |
| Italy | 9.8 | 12.6 |
| Netherlands | 8.5 | 16.3 |
| Spain | 7.0 | 12.5 |
| Sweden | 9.9 | 21.5 |
| U.K. | 8.9 | 19.1 |
| U.S.A. | 8.0 | 20.0 |
| | | |

Source: "The Drug Companies", Worker's Research Unit Bulletin, No. 3, Belfast, 1978, p. 29.

Canadian women always had a tranquilizer within easy reach. ⁵⁹ A recent U.S. study ⁶⁰ by the National Institute on Drug Abuse showed that 60% of psychotropic drugs, 71% of anti-depressants and 80% of

⁵⁹H. Worthington, "Go home, take a tranquilizer-be happy", <u>The Toronto Star</u>, Feb. 19, 1977, p. Fl.

amphetamines were prescribed for women. 60 Researchers Parry and Cisin 61 found that in 1971, 13% of U.S. males and 29% of females used psychoactive drugs. Six per cent of males and 12% of females used these substances for periods of one to six months and longer. 62

A 1977 Ontario Gallup Poll⁶³ showed that while more women than men report use of these drugs for one or two-day periods, the difference in consumption patterns between males and females widens greatly the longer the period studied. One study ⁶⁴ of a Southern Ontario insurance plan showed that more

M. Nellis, <u>Drugs</u>, <u>Alcohol</u> and <u>Women's Health</u>, National Institute on Drug Abuse of the U.S., Department of Health, Education and Welfare. (This report is under internal review by the Task Force for Women's Concerns within the National Institute on Drug Abuse. It has not been relased publicly.) cited in <u>The Globe</u> and <u>Mail</u>, Thurs., April 27, 1978, p. T5.

⁶¹ Cited in S. Wolfe, op.cit., pp. 54-55.

⁶³ Provisional Results of Gallup Survey, 1977, Commissioned by Non-Medical Use of Drugs Directorate, Department of National Health and Welfare, Ottawa, 1977.

⁶⁴ R. Cooperstock, "Psychotropic drug use among women", op.cit.

females than males received multiple tranquilizer prescriptions during the year. More than double the number of females than males received ten or more prescriptions, indicating steady use over the year.

There are significant differential factors such as age, work position, etc. among the female population receiving drugs. Most U.S. studies have found peak drug use among females in their middle years. One survey established that women in the 40-59 age group were the highest consumers of psychotropic drugs. The researchers also noted "the higher proportion of women perceived as presenting vague symptoms such as headache, vertigo, fatique, lassitude". Once again, symptoms showing no distinctive physiological origins. In another survey 87 80% of the doctors responding agreed that "certain medications are often very

⁶⁵R. Cooperstock, "A Review of Women's Psychotropic Drug Use," op.cit.

⁶⁶ R. Cooperstock, "Social Aspects of the Medical Use of Psychotropic Drugs," op.cit., p. 26.

L.S. Linn, "Physician characteristics and Attitudes toward legitimate use of psychotherapeutic drugs," J. Health Soc. Behav., 12, 1971, pp. 132-140.

helpful in handling the social demands and stresses of everyday living." Thirty-three per cent of the doctors said that daily Librium use was acceptable as therapy for a middle-aged woman with marital problems.

A Canadian study by the Addiction Research Foundation found that: in the over-65 age group 19% of males and 30% of females had one or more prescriptions of psychoactive drugs in 1974, in the 20-49 age group the figures are 7% male and 13% female.

The age variable may be confused with the work status variable. The variable of work status remains consistent in relation to psychotropic drug use among both sexes. The highest consumers of drugs are those retired, unemployed or outside the labour force. Guse et al. in a Winnipeg study discovered that at each age level women who worked outside their

⁶⁸Greenshield Prescription Plan Study on file at the Addiction Research Centre.

Guse, G. Morier, J. Ludwig, "Winnipeg Survey of Prescription (Mood-Altering) Use Among Women", <u>Technical Report</u>, NMUDD, Manitoba Alcoholism Foundation, Oct. 1976.

homes showed lower drug use than those who did not.

Eleven per cent of those women who worked full-time outside the home, 19% of those with part-time jobs and 25% of those at home full-time reported drug use in the previous two weeks. Guse's results have been corroborated in a 1978 Ontario study titled "Women's Use of Psychotropic Medicine". This study found that among women who did not work outside the home, 19.7% reported taking medication in the previous 48 hours compared with 10% of women with jobs.

Women who fulfil the most traditional female roles are those who are most often prescribed tranquilizers. Ruth Cooperstock of the Addiction Research Foundation in Ontario comments that

"Most people think that working women are under the most stress and turn to tranquilizers to relieve their anxiety. The truth is that women who work are healthier over-all and far less likely to turn to tranquilizers than the woman who chooses to stay at home."71

⁷⁰Committee Concerned with Women's Health Issues, Women's Use of Psychotropic Medication, Ontario, 1978. Cited in The Globe and Mail, April 25, 1978, p. 16.

⁷¹ Cited in H. Worthington, op.cit., p. Fl.

Women attend physicians' offices more than men and consequently receive more drugs. Parallel to the findings linking drug use with age and employment outside the home it has been demonstrated the increasing age and lack of employment outside the home predisposes one to more frequent visits to doctors. 72

The key question remaining is whether physicians prescribe differently to male and female patients presenting with the same "symptoms". One study and in a long term care facility for the elderly found that more women than men were defined by the staff as anxious; but with the anxiety level held constant more women than men were given drugs. A study in a family practice clinic observed patients who were unhappy, crying, depressed, nervous and

⁷²C.A. Nathanson, "Illness and the feminine role: A theoretical review", Soc. Sci. Med., 9(2), 1975, pp. 57-62.

J.W. Milliren, "Some contingencies affecting utilization of tranquilizers in long-term care of the elderly", J. Health Soc. Behav., 18(2), 1977, pp. 206-211.

⁷⁴ Cited in R. Cooperstock, "A Review of Women's Psychotropic Drug Use", op.cit., p. 33.

worried, restless and tense. Among the patients, more females than males were prescribed minor tranquilizers. Prescriptions for tranquilizers increased in proportion to total female visits, but did not proportionately increase for male visits.

The most frequent symptom requiring drug therapy is anxiety, a common enough human state.

"We know from a great variety of sources that such drugs are used for organic diseases where they are not indicated, are used for the treatment of garden—variety unhappiness, frustration, and normal states of sadness.

Many within the medical profession seem to have come to believe that anxiety is abnormal and must be prevented or controlled through the use of drugs."75

Doctors are frequently presented with patients suffering from marital discord, fatigue, loneliness, anxiety or general depression. Advertisements in medical journals skillfully exploit these everyday problems. Valium has been advertised as "psychic support for the tense insomniac", for the "always

⁷⁵ S. Wolfe, <u>op.cit.</u>, p. 55.

weary" for "somatic symptoms of psychic tension."⁷⁶
The advertisements further try to induce the doctor
to use drugs where he would not have previously done
so, and to treat problems of irritating or demanding
patients by means of drugs.

"It would appear that the industry is attempting to convince the physician-consumer that new, nonillnesses require therapeutic intervention. It is probably the case that a high proportion of the psychotropic drug advertisements reflect and reinforce values already held by the physician. Many advertisements also attempt to play upon the anxieties experienced by some physicians. For example, a recent advertisement for Stelazine pictured six photographs of the same unhappy looking women with the accompanying text, "You've talked ... You've listened ... But here she is again". In other words, at the moment the physician can no longer cope with a complaining or demanding patient or is overwhelmed by her, the only alternative is tranquilization."77

Despite the fact that advertisements are clearly not requisite resource materials for scientific medicine, they play a great part in

⁷⁶ I. Waldron, op.cit., p. 41.

⁷⁷ Ibid.

influencing doctor's prescribing behaviour. A comprehensive study ⁷⁸ discovered that about half of the physicians observed used journal advertisements as sources of drug information about once per week.

Dr. Katz, chairman of the Consumer's
Association of Canadas' committee of health affairs
says:

"Doctors should learn about drugs from scientists, not drug companies." 79

Dr. Katz complains that much of the advertising material on tranquilizers promotes inappropriate or dangerous prescribing practices. He notes that they often depict frowning women implicitly burdened with household chores and the demands of active children.

In a content analysis of advertisements in three medical journals and one psychiatric journal in the United States, Prather and Fidell⁸⁰ document some

⁷⁸ Subcommittee on Health Committee on Labor and Public Welfare, U.S. Senate, Examination of the Pharmaceutical Industry, 1973-4, U.S. Government Printing Office, Washington, 1974, pp. 143-157.

⁷⁹J. Doig, <u>op.cit.</u>, p. 5.

Cited in R. Cooperstock, <u>Social Aspects of</u> Psychotropic Drugs, op.cit., p. 28.

of the biases in advertisements for psychotropic drugs. The authors found a direct relationship between the type of illness depicted and the sex of the patient. They found a disproportionate number of women pictured as suffering emotional illness and too few as shown with somatic illness. Women were primarily shown suffering from diffuse anxiety and tension. Valium is promoted for the housewife "with too little time to pursue a vocation for which she has spent many years in training".81 Librium is promoted for use "when anxiety and tension create major discord in parent-child relationships "82 for the female college student whose new experiences "may force her to re-evaluate herself and her goals" and whose "newly stimulated intellectual curiosity may make her more sensitive to and apprehensive about unstable national and world conditions."83

Are the minor tranquilizers effective on their own terms? Most studies demonstrate little differences

⁸¹_Ibid.

⁸² Ibid

⁸³ Ibid.

in rates of improvement between drug and placebo users. 84a Especially in terms of prolonged usage, differences between Valium and placebo became insignificant. Studies have shown that a substantial number of persons suffering from such symptoms as anxiety, improve spontaneously. 84b The U.S. Food and Drug Administration in January 1978 alerted doctors to the fact that there is no evidence that Valium, Librium and other minor tranquilizers were effective in long-term use.

Sociologist Harry Lennard states,

"Within the medical/technological model of drug use, the only effects of psychoactive drugs that have been examined, are on the "symptoms" of the "diseases" of individuals.

... The drugs decrease the anxiety or unhappiness of the individual and, more important, they decrease the amount of trouble his anxiety or unhappiness causes others. It is thus easier for other persons

⁸⁴aL. Arfwidsson, L., Arn, J., Beskow and G. Persson, "A comparison between diazepam, dixyrazine, opripramol and placebo in anxiety states", Acta Psychiatr. Scand. (Suppl. 221), 1971, pp. 19-32. And R.B. Sloane, F.R. Staples, et.al., Pyschotherapy vs. Behaviour Therapy, Cambridge, Harvard University Press, 1975.

⁸⁴b Ibid.

to manage or to cope with the disturbed or disturbing individuals. The drugs do not, however, reach the sources of anxiety or misery...To the extent that drugs dull the senses, sedate, numb and immobilize, drugs tend to make things easier for the giver as well as the user. For the giver, the use of drugs diminishes the strain of having to accommodate to difference and deviance in others; the user too is relieved of the burden of adjusting to interpersonal differences since he tends to interact in the "same modality" as other users of the same drug, without effort ... they dedifferentiate human experience and behaviour. They make persons more homogeneous by restricting variability in sensation and experience; yet it is precisely for this property that many psychoactive drugs are prescribed."85

New drugs have been introduced into the widest possible circulation before their more unfortunate side effects have been discovered. Psychoactive drugs have a common social history from their synthesis, when the medical profession makes sweeping claims for their wondrous properties, to their public acceptance, when their negative effects become

⁸⁵H.L. Lennard and A. Bernstein, "Perspectives on the New Psychoactive Drug Technology", in R. Cooperstock, op.cit., pp. 158-159.

apparent.

For instance, chlorpromazine was synthesized in 1951 and introduced to the public in 1954 after few tests. Within one year, this drug had been administered to over two million patients in the U.S. as a "safe" drug. Subsequent studies demonstrated that at low doses the drug was little more effective than a placebo, but higher doses did (as one would expect) make hospital patients more docile and manageable. 86

As these studies were being performed evidence of the drug's negative effects began to accumulate.

One syndrome, "tardive dyskinesia", which develops an uncontrollable and in many cases irreversible twitching of the face and limbs was discovered in patients receiving chlorpromazine or other phenothiazines for more than one year. This syndome was described in the late 'fifties, but drug

⁸⁶A.T. Scull, <u>Decarceration</u>: The Community <u>Treatment of the Deviant</u>: A Radical View, N.J., Prentice-Hall, 1976.

⁸⁷ I. Waldron, op.cit.

companies saw fit to leave out any mention of it in their package insert or drug displays until 1971. 88

In the case of the amphetamines, 89 meprobamate 90 and glutathimide, early claims were made for their safety, efficacy and even for their non-addicting nature. After these drugs achieved widespread use all the above claims were demonstrated to be false.

It should be remembered that both heroin and morphine were initially introduced as non-addicting. 92 One consequence of this historic pattern for drug introduction and prescription is that the average

Crane, G.E., "Clinical psychopharmacology in its 20th year", Science, 181, 1973, pp. 124-128.

⁸⁹ L. Grinspoon and P. Hedblom, The Speed Culture: Amphetamine Use and Abuse in America, Cambridge, Harvard University Press, 1974.

⁹⁰D.J. Greenblatt and R.I. Shader, "Meprobamate: A study of irrational drug use", Am. J. Psychiatry, 127 (10), 1971, pp. 1297-1303.

⁹¹ P.A. Parish, "The prescribing of psychotropic drugs in general practice. J.R. Coll. Gen. Pract., 21 (Suppl. 4), 1971, pp. 1-77.

⁹²M. Silverman and P.R. Lee, <u>Pills</u>, <u>Profits</u> and <u>Politics</u>, Berkeley, University of California Press, 1974.

life expectancy of a drug on the U.S. market from introduction to withdrawal is a mere five years. 93

Even the so-called minor tranquilizers engender a host of crippling side effects. Among the common side effects of Valium and Librium are drowsiness, confusion and muscular incoordination. 94 Librium decreases scores on intelligence tests. Paradoxically, Valium and Librium both have been known to increase aggressiveness. 95 Dr. Susan Stephenson, associate professor of child psychiatry at the University of British Columbia, described one case history where a young mother was prescribed tranquilizers by her family doctor to relieve "normal" post-partum depression. After taking the medication the woman

⁹³E. Hemminki, "Review of literature on the factors affecting drug prescribing", Soc. Sci. Med., 9, 1975, pp. 111-115.

Medical Letter on Drugs and Therapeutics Reference Handbook, Medical Letter, Inc. New Rochelle, N.Y., 1973, pp. 3-5.

⁹⁵D.J. Greenblatt and R.I. Shader,
Bezodiazepines in Clinical Practice, Raven Press, N.Y.
1974.

developed strong urges to kill her baby, which ceased with the termination of the medication. 96

Other side effects noted 97 have included double vision, fainting, tremors, dizziness, anxiety, hallucinations, muscle spasticity, rage, hypotension, jaundice, insomnia and addiction. The minor tranquilizers have also been linked with birth defects. With the increase in psychoactive drug prescription, there has been a vast increase in drug dependency, adverse drug effects, hospitalization for overdose and accidental and suicidal deaths. 98

In the U.S. it has been estimated that 5% of hospital patients have drug-induced illness. Between 10% and 30% of all hospital patients experience adverse drug reactions at some time during their hospital stay. Approximately, 30,000 people die yearly in the U.S. from adverse drug reactions. 99

^{96&}lt;sub>J. Doig, op.cit.</sub>

⁹⁷ Ibid and I. Waldron, op.cit.

⁹⁸ A. Klass, There's Gold in them thar Pills, Penguin, 1975.

⁹⁹ Worker's Research Unit Bulletin, op.cit., pp. 26-30.

An added burden shouldered by women who are prescribed psychotropic drugs is that of cross-addiction. 60% of those seeking assistance for depression have alcohol problems, 33% of them are women. Eighty per cent of women alcoholics reported that they used other drugs as frequently as alcohol leading to multiple drug abuse and cross-addiction. 100 In Metro Toronto 101 it has been estimated that 30% of women entering treatment centres for alcoholism are cross-addicted. Many of the women with these problems are "hidden", that is, they are alone during the day, not visible and thus not part of any statistical picture.

The picture which emerges from the above data is as follows. More women than men are prescribed and take psychotropic drugs. These drugs do not appear "effective" on their own terms, that is they do not achieve remission of symptoms. Further, they

^{100&}lt;sub>N</sub>. Nellis, Drugs, <u>Alcohol and Women's</u> <u>Health</u>, op. cit.

¹⁰¹ Cited in D. Hopper, "Deadly double of drink, drugs hooks thousands", The Toronto Star, May 6, 1978, p. Gl.

are likely to have damaging side effects. Nonetheless, they continue to be in increasingly widespread use.

c. Psychosurgery

Psychosurgery is the most dramatic and the least publicly visible of the physical methods of therapy. Psychosurgery involves physical intrusion into the brain and the destruction or excision of brain matter. Its forms range from almost indiscriminate cerebral assault with a knife to the implantation of radium seeds to irradiate a more discreet area of the brain.

The procedure may be viewed as an extreme prototype of all behaviour modification. It embodies all the problems which inhere in other forms of behaviour control and psychiatric intervention in human activity. Furthermore, psychiatric surgery is presently undergoing a great rebirth. For these reasons, psychosurgery is clearly a subject worthy of attention.

P.R. Breggin, M.D., Statement in Congressional Record, 118, March 30, 1972.

"While psychosurgery may be similar to other forms of behaviour modification, the immediacy of its effect and the totality of control possible suggest a coercive potential beyond that inherent in the more gradual procedures." 103

Gottieb Burckhardt in Switzerland, in the 1890s, in order to pacify some patients in his care. 104 The public outrage was so great that the practice did not reappear until Egan Moniz, John Fulton and Walter Freeman met in 1936, to observe the effects of lobotomy on two monkeys and a man. 105 From this, Moniz went to operate on mental hospital inmates in Portugal. His career was terminated when a patient maimed him with five shots, and the state hospital psychiatric director refused to allow him to continue to operate. Moniz did however, receive the Nobel prize for his efforts.

W.M. Gaylin, J.S. Meister and R.C. Neville, Operating on the Mind, New York, Basic Books, Inc., Publishers, 1975, p. 7.

¹⁰⁴E. Moniz, "Attempt at Surgical Treatment of Certain Psychoses", in R. Wilkins, (ed.), Neurosurgical Classics, Johson Reprinting Corp., 1965.

E. Valenstein, <u>Brain Control</u>, N.Y., John Wiley, 1973.

Walter Freeman introduced lobotomy to North

America. He elaborated the "ice-pick" method (and

used it personally of Frances Farmer). Freeman would

force an instrument resembling an ice-pick through

the skull immediately above the orbit of the eye into

the brain. It would then be manipulated so as to cut

the bottom sections of the frontal lobes, incidentally

damaging the surrounding tissue. 106

The untoward side effects of lobotomy were not immediately visible, as the technique was initially confined to chronically hospitalized psychotic patients. These effects were to become apparent with the increasing use of psychosurgery and also with the introduction of neurotics and individuals with psychosomatic complaints as subjects. Some estimates suggest that by the 1950's, over 100,000 lobotomies had been performed worldwide, 107 with 50,000 in the U.S. alone. 108 In that period some psychosurgeons

¹⁰⁶Cited in A. Mazur and L.S. Robertson, Biology and Social Behavior, N.Y., Free Press, 1972, p. 131.

J. Older, "Psychosurgery: Ethical Issues and a Proposal for Control", Amer. J. Orthopsychiat., 44(5), October 1974, pp. 661-674.

¹⁰⁸ J. Agel, Rough Times, New York, Ballantine Books, 1973, p. 199.

performed fifty lobotomies per day. 109 Walter Freeman himself performed over 4,000 through his lifetime. 110

The real nature of the "cure" was impossible to ascertain, principally because psychosurgeons kept little or no records, no controls were maintained and few follow-up studies undertaken. Experts have described the lobotomy period as one of the shabbiest in the entire history of mental health care. 111 Dr. Peter Breggin discusses one British surgeon who performed 4,000 operations without any follow-up studies, either published or unpublished. 112

The "cure" began to appear to be quite shallow. Schizophrenics prior to lobotomy were still schizophrenic after. The patients were not rendered simply calm, but also apathetic, irresponsible and asocial. Freeman noted that "(t)he patient who has undergone extensive psychosurgery is at first immature

¹⁰⁹ S. Chavkin, The Mind Stealers, Boston, Houghton Mifflin Company, Boston, 1978, p. 23.

¹¹⁰ S.L. Chorover, "The Pacification of the Brain", Psychology Today, May 1974.

¹¹¹E. Valenstein, op.cit., p. 313.

¹¹² P.R. Breggin, M.D., op.cit.

in his reactions, going about carelessly dressed, responding hastily and sometimes tactlessly, and indulging his appetites for food, drink, sex, repose, and spending money with little regard for the convenience or welfare of others."113

The patient's intellect was blunted, judgement impaired and creativity reduced. In some cases, lobotomy induced complex metabolic changes which led to wasting of the body, weakness, coma and death. 114

By the early 1950's, tens of thousands of human "retreads" were visible, many of whom had become vegetable-like as a result of lobotomy.

In any event, the lobotomy boom of the '40s was certainly spent by the '50s, not because of any public outcry, but because of the introduction of psychoactive drugs and sophisticated electroconvulsive treatments. Recently, however, the practice is being resurrected. In fact the fate of the practice of psychosurgery appeared sealed with the First

¹¹³W. Freeman, American Handbook on Psychiatry, Vol. 2, N.Y., Basic Books, 1959, p. 1524.

 $^{^{114}\}mathrm{S.L.}$ Chorover, "The Pacification of the Brain", op.cit.

International Psychosurgical Congress in 1948 was not followed by a second one in 1949 or even in 1959. However the Second Congress did convene in 1970 at the beginning of the new resurgence of the psychosurgery movement. The Third Congress met in 1972. 115

Psychosurgery can be viewed as brain surgery performed to "alter thoughts, social behavior patterns, personality characteristics, emotional reactions, or other aspects of subjective experience in human beings." 116 It does not encompass surgery designed to alleviate specific types of neuropathology such as tumours, etc. It must be emphasized that psychosurgery is surgery performed in the absence of any evidence of organic brain pathology. 117 Peter Breggin, a vigorous opponent of psychosurgery whose 25,000 word denunciation of the practice was inserted in the Congressional Record of 1971, defines

W. Sweet, "Treatment of Medically Intractable Mental Disease by Limited Frontal Leucotomy - Justifiable?", New Eng. J. Med., 289: 1117-1125.

¹¹⁶S.L. Chorover, "The Pacification of the Brain", op.cit., p. 59.

¹¹⁷ National Commission's Recommendations, Federal Register. Cited in S. Chavkin, op.cit., p. 121.

psychosurgery as follows:

"Psychosurgery is any surgery which mulilates or destroys brain tissue to control the emotions or behavior without treating a known brain disease. In 99% of the cases, the brain surgery will actually attack normal tissue. In a few cases, some brain disease will be present, but in these instances, the brain disease will have nothing in particular to do with the symptoms which the surgery is attacking. Thus, psychosurgery is a pacifying operation which blunts the emotions and subdues behavior regardless of the presence or absence of any brain disease or any particular psychiatric problem. It is simply a mutilating operation whose effect is to destroy the individual's ability to respond emotionally."118

The U.S. National Institute of Mental Health categorically states that psychosurgery is brain surgery performed in the absence of direct evidence of existing structural disease of damage of the brain.

The modern techniques concentrate on the thalamus, the cingulate gyrus and the amygdala. These

¹¹⁸ p.R. Breggin, M.D., op.cit., p. 11396.

Cited in S. Chavkin, op.cit., p. 21.

are parts of the limbic system. The mechanisms of the limbic system are thought to contribute to an individual's sense of individuality, concepts of reality and self preservation behaviour. 120 In order to justify this sophisticated neural intrusion, psychosurgeons cling to the theory of brain localization. The theory holds that very specific areas of the brain directly control certain discreet behaviour, and are not connected with other areas. This theory is not widely favoured among medical scientists. Most argue that there is no proof of any direct ties between specific brain abnormalities and corresponding behaviour disorders. 121

In fact, the most modern techniques are not able to clearly monitor minute brain functions. Even with pathological findings in the brain no one is yet sure of their casual significance in behavioural terms. Neurophysiologist Donald Rushmer holds:

¹²⁰ s.L. Chorover, <u>op.cit.</u>, p. 63.

¹²¹ Ibid., p. 69.

"It is no understatement to say that we have barely scratched the surface with our present knowledge of how even the simple nervous system of the frog really works, let alone how the billions of nerve cells in the human brain interrelate to give the range of emotions, intellect and abilities we so often take for granted ..."122

The current rate of psychosurgery (U.S.) is estimated at 600-1000 cases annually. ¹²³ This may be the beginning of a resurgence. At present psychosurgery is practiced in Canada, Australia, France, Spain, Italy, W. Germany, Norway, Sweden, Denmark, Finland, Switzerland, Thailand, India, Japan, Great Britain and the U.S. ¹²⁴ Soviet Russia prohibited the practice in 1951.

The "new wave" of lobotomy began in the late 1960's. Psychosurgery began to be experimented with as a universal cure for psychosis, homosexuality, pedophilia, "frigidity", "nymphomania", alcoholism,

¹²² Cited in S. Chavkin, op.cit., p. 34.

^{123&}lt;sub>W.M.</sub> Gaylin, et al., op.cit., p. 8.

¹²⁴Boston University Law Review, <u>Psychosurgery</u>, Mass., Lexington Books, 1976, p. 35.

¹²⁵ Ibid.

drug addiction, compulsive stealing, and compulsive gambling. 126 Its subjects have included prisoners, depressed older women, obsessive-compulsives, anxious types, epileptics, hypochondriacs and "hyperkinetic" children. 127 Whereas psychosurgery in the 1940's concentrated on "psychotic" patients. The trend in the new wave of psychosurgery is to aim at a much broader target group. This group is diagnosed as suffering from mild forms of disturbance such as neurosis 128 and women appear to be the major subjects for psychosurgical operations.

"In fact ... the majority of patients operated on in America are women with neurotic problems."129

Recently, an ardent defender of psychosurgery, Dr. O.J. Andy, was commissioned by the U.S. Government to investigate surgical treatment of those suffering from "very mild emotional or neurotic disturbances".

^{126&}lt;sub>J</sub>. Older, op.cit., p. 662.

¹²⁷Medical World News "Psychosurgery critics prove hard to mollify", April 14, p. 38-39.

W. Sweet, op.cit. and O. Andy, "Neurosurgical treatment of abnormal behavior," Amer. J. Med. Sci., 132: 232-238.

¹²⁹ P.R. Breggin, M.D., op.cit., p. 11396.

It is interesting to read Dr. Andy's definition of "symptoms" which require surgical intervention. The title of his treatise is "Neurosurgical Treatment of Abnormal Behavior".

"Symptoms which characterize the abnormal behaviour in this treatise are emotional tension, anxiety, aggressiveness, destructiveness, agitation, distractability, attack, suicidal tendencies, nervousness, mood oscillations, stealing, rage, negativism, combativeness, and explosive emotions. These various symptoms or syndromes contribute to a social maladjustment for which society demands correction or appropriate control." 130

The horizons for the modern psychosurgeon are considerably broader than those of the old lobotomists. Now tense, nervous, combative people are subjects for surgical personality alteration, as are stealers.

Freeman informs us of the preferred categories of subjects for psychosurgery:

^{0.} Andy, <u>op.cit.</u>, p. 232.

"First, "older patients."
Second, women more than men.
Third, negroes especially,
particularly Negro females,
the most successful group.
Fourth, "simpler" occupations".

Jackson and Jaco (in 1954) concur. Their profile for an ideal patient shows that the "most promising" candidate would be a Protestant (Baptist or Methodist) married, Black women with 11-12 years of schooling and a history of venereal disease. The patients most and least likely to improve are as follows:

"MORE LIKELY TO IMPROVE"

- 1. Sex: female
- 2. Color: Negro
- Diagnosis: involutional, or schizophrenic, and/or paranoid types
- 4. Duration of Illness: less than 2 years
- 5. Duration of Hospitalization: Less than 1 year
- 6. Previous Treatment: Less than 10 EST's
- 7. Marital Status: married
- 8. Education: 11-12 years
- 9. Occupation: Service occupations
- 10. Church Affiliation: Protestant Baptist

F. Freeman and J. Watts, <u>Psychosurgery</u>, Charles C. Monas, 1970.

C.L. Jackson and E.G. Jaco, "Some Prognostic Factors in 538 Transorbital Lobotomy Cases", in Amer. J. Psychiat., 1954, No. 111.

"LESS LIKELY TO IMPROVE"

- 1. Sex: male
- 2. Color: White
- 3. Diagnosis: psychosis with mental deficiency, psychosis with convulsive disorders, or psychosis with meningoencephalitis
- 4. Duration of Illness: 10 or more years
- 5. Duration of Hospitalization: 2 or more years
- 6. Previous Treatment: 15 or more ICT's, or over 70 EST's
- 7. Marital Status: single
- 8. Education: illiterate or 6 years
- 9. Occupation: agriculture
- 10. Church Affiliation: Catholic, or none
- 11. Venereal History: negative
- 12. Readmission Status: none 133

Breggin explains why women make ideal subjects:

"Not only have the vast majority of patients been women, both in the past and in the current literature but the two most indepth prolobotomy studies have already told us that psychosurgery is much more effective on women than on men because women can more easily be returned home to function as partially crippled, brain damaged housewives, while there are no social or occupational roles for partially crippled, brain damaged men." 134

Similarly Walter Freeman writes that women are more

¹³³ Ibid., p. 357.

¹³⁴ P.R. Breggin, M.D., op.cit., March, p. 11399.

likely than men to return home following lobotomy because it doesn't take much "for a wife to keep house". 135 And Sargant and Slater have argued it is reasonable to lobotomize a woman rather than alter an oppressive or psychogenic family environment.

"Another type of depressive illness that may be helped by leucotomy is the reactive depression in which environmental factors of an irremediable kind are involved. A depressed woman, for instance, may owe her illness to a psychopathic husband who cannot change and will not accept treatment. Separation might be the answer, but is ruled out by other ties such as children, by the patient's financial or emotional dependence, or by her religious views. Patients of this type are often helped by anti-depressant drugs. But in the occasional case where they do not work, we have seen patients enabled by a leucotomy to return to the difficult environment and cope with it in a way which had hitherto been impossible."136

Following a provision prohibiting operations

¹³⁵Cited in A U.C.L.A. Centre for Psychosurgery?, S.D.S., 1973, p. 3.

¹³⁶W. Sargant, E. Slater and D. Kelly, <u>An</u>
<u>Introduction to Physical Methods of Treatment in</u>
<u>Psychiatry</u>, London, C. Livingston, 1972, pp. 105-106.

on males in Kingston Psychiatric Hospital, Ontario,
Drs. Hetherington, Haden and Craig, in 1970, lobotomized
17 women. 137 Still in Canada, Dr. Baker, Assistant
Professor of Psychiatry, University of Toronto,
reports (in 1970) operating on 44 cases - 27 female
and 17 male (from 1959-1968), 48% of the women had
an "excellent" result as compared to 23% of the men!
Baker gives some rather enlightening anecdotes to
support his use of frontal lobotomy. Case No. 1 is
a suburban housewife who is promiscous, runs away
from home and is suicidal on occasion. After
lobotomy she is no longer promiscuous and becomes a
faithful partner in marriage. 138

Dr. Lindstrom, in 1964, wrote of operations on 60 "psychotics" and 154 "neurotics" - 72% of the "psychotics" and 80% of the "neurotics" were female. 139

Cited in P.R. Breggin, M.D., Congressional Record, 118, Feb. 24, 1972, p. 5569.

¹³⁸ Canadian Medical Association Journal, Jan. 17, 1970, p. 102.

¹³⁹ Cited in A U.C.L.A. Centre for Psychosurgery?, op.cit., p. 3.

By 1972 Lindstrom claimed to have operated on 550 patients, mostly neurotics, 80% female. He cites one case where a thirteen year old girl was brought to him because she hated school and refused to go, claiming she was ill. Following treatment "she was able to return to school and has now attended school regularly for four years, achieving passing grades. She has been helping with the work at home." 140 Lindstrom gives no indication of the girl's ability prior to treatments. When he was asked why so many of his patients were women he stated somewhat candidly:

"Women are subjected to severe anxiety and depression. They have nothing to fall back on. I would go nuts myself if I were placed in the same situation." 141

Dr. M. Hunter Brown, an extreme enthusiast of psychosurgery operating in California, performed 200 operations prior to 1972, 72% on women. He is now performing 100 operations yearly. Hunter Brown proudly displayed one of his specimens at a 1973 psychosurgery conference. The patient was a woman who

A. Spake, "Women and Psychosurgery: Rape by Scalpel" cited in <u>Viva</u>, 1977, p. 46.

¹⁴¹ Ibid.

had suffered from depression and neurotic compulsions. Her compulsive actions centred on her housework chores. Her husband, a California minister stated:

"My wife could not put things away. The groceries were stacked on the kitchen table and her clothes were not hung up in the closet but were hung outside the door. She would repeat one thing from five to thirty times, like putting something away, so eventually she didn't put it away... Mostly we did not eat at home, or I would bring food in because she couldn't put the dishes away afterwards. The cooking wasn't so hard, it was putting the dishes away." 142

The "consent" to operate was obtained in an interesting manner. The patient related the story:

"My husband talked to my psychiatrist without my knowing it and he referred me to Dr. Hunter Brown. My husband investigated Dr. Brown without my knowing it and when he was thoroughly convinced, he popped me with it ... Psychosurgery, I had never thought of such a thing, not knowing anything about it. It took me about half a day to give consent, and within a few days I was in hospital." 143

^{142 &}lt;u>Ibid.</u>, p. 60.

¹⁴³ Ibid.

The results of the operation were that the woman became a model housewife.

"I enjoy keeping house, cleaning house. I can eat my own cooking and cook for my husband. I enjoy social life quite a bit ... I have much deeper religious feeling, which is important to a minister's wife. The depression is just gone. I don't think of it any more ..."144

Dr. Ballantine, of Massachussetts General, operated, in 1967, on 40 patients, 65% women. Drs. Hunter and Lighthill (Santa Monica) state (1972) that out of 110 cases, 72 were female. Drs. Bailey and Dowling (Sydney, Australia) report in 1971, operating on 100 cases - 64 women. Hohne and Walsh (Melbourne, Australia) report in 1970, on a study involving 250 patients - 182 were women. These operations strove to achieve "the surgical modification of personality ... quite simply, to move

¹⁴⁴ Ibid.

Psychosurgery? op.cit. Patient selection based on "classic" Study by Jackson and Jaco, op.cit.

H.H. Hohne and K.W. Walsh, <u>Surgical</u>
Modiciation of the Personality, MHA Special Pub.,
Melbourne, 1970.

the patient by surgery, back along this continuum without pushing him (her!) beyond the range of what is clinically and socially acceptable (sic)."¹⁴⁷A follow-up study of 1,000 lobotomies in England and Wales¹⁴⁸ found that 654 subjects were female. The intentions of the operations were "to break the connection between the patient's thoughts and her (her!) emotions."¹⁴⁹ The subjects ranged from "schizophrenics" to "mental defectives" to "neurotics". Only 24.8% "recovered". In all the above studies, without exception, the information concerning the sexual distribution of patients is hidden in footnotes, or charts.

One study which Dr. Peter Breggin describes as the only detailed clinical study concerns a woman named Ann. Ann's mother first brought her to the attention of psychiatrists at Massachussetts General

¹⁴⁷ Ibid., p. 71.

¹⁴⁸I. Wilson and E.H. Warland, "Prefrontal Leucotomy in 1,000 Cases", G.B. Board of Control (England and Wales), London HMSO, 1947. (Abstract in Lancet, 1947, 252, pp. 265-266)

¹⁴⁹ Ibid.

¹⁵⁰ Cited in J. Older, op.cit., 667-668.

Hospital. She claimed that something must be done about her daughter's agitated and depressed mental state. Ann had a history of psychiatric disturbance which centred on her father's death and her mother's hostile and domineering attitude towards her.

Doctors Mark and Ervin decided to find the root cause of Ann's depression by implanting deep electrodes into Ann's brain and charting her responses. When the current flowed into her thalamus Ann reportedly shouted "don't do that:" Based on this evidence of discomfort the doctors arrived at the obvious conclusion — that the thalamus was the site of Ann's depression.

Using a radio frequency current Mark and Ervin proceeded to sear a lesion in her thalamus. The electrode was left in to coagulate the tissue following the operation. Ann became confused after this procedure and her moods swung between euphoria and deep depression. She became enraged at her physicians, surgeon and psychiatrist. This earned her a further label - paranoid.

The doctors decided that one operation was clearly insufficient, and concluded that Ann's brain

needed further surgical attention. She was operated on again and the thalamic lesion enlarged. Now Ann's confusion and mood swings became more acute, her memory was impaired and she was unable to find her way around the ward. In her depressive phases she wished for someone to cut her throat. The doctors decided to operate a third time.

After the third operation Ann said she'd never let them do it to her again. In one of her euphoric periods the doctors gave Ann a pass to go out shopping. Ann went into a phone booth, phoned her mother to say good-bye, and killed herself with poison she had brought into the hospital and kept with her throughout the entire ordeal.

Mark and Ervin wrote this case up as a "success". They found the results "gratifying" and an exoneration of psychosurgical techniques. They found that Ann's mind had become so clear and organized that she could carry through the suicide she had formulated earlier.

"It was gratifying that the severe memory loss in this patient was not permanent ... In fact, her memory was well enough organized to carry out a suicide plan that she had formulated nearly 5 months previously." 151

Psychosurgeons Vaernet and Madsen admit that their foremost purpose is not the alleviation of disease. They attempt a "reduction in, or abolition of, hostile-destructive episodes and anti-social behavior." They cite cases as examples of 'successful' operations: Case Two: "She is still withdrawn and avoids emotional contact but is helpful in the ward, running errands, etc."; Case Three:

"The patient is quiet and cooperative, she is receiving elementary school training and helping with various tasks in the ward."; Case Six: "After the amygdalotomy she has been much more quiet". All of the patients cited, were female. The above study is

^{151&}lt;sub>V</sub>. Mark, et al., "The destruction of both anterior thalamic neuclei in a patient with intractable agitated depression", <u>J. Nerv. Ment. Dis.</u>, 150, 1970, pp. 266-272.

¹⁵²K. Vaernet and A. Madsen, "Sterotaxic Amygdalotomy and Basofrontal Tractomy in Psychotics with Aggressive Behavior", in <u>J. Neurol. Psychiat.</u>, 1970, pp. 3858-63.

also typical in that the vaguest of evidence (or either the rationales for, or results of the operations) is provided. Thus, "success" rates claimed by psychosurgeons must be viewed with extreme suspicion.

Psychosurgeon Balasubramaniam 153 reports a success rate of 75.6% in his operations, which is quite impressive. However, Balasubramaniam included those who were "manageable when given drugs though not leading a useful life", 154 following psychosurgery. Most standards would not rate such patients as "successful" results of operation. If this group is eliminated, the success rate plummets to 38.2%. Narabayashi and Uno 155 report a success rate of 68%. However, their figures includes young children who have been operated on. If children under eleven

¹⁵³V. Balasubramaniam, T. Kanaka and B. Ramanurthi, "Surgical Treatment for hyperkinetic and behavior disorders", <u>International Surgery</u>, 1970, 54, pp. 18-23.

¹⁵⁴ Ibid., p. 21.

Cited in J. Older, op.cit., p. 664.

years are excluded from the figures the success rate drops to 31%. Such success rates are not very impressive. Traditional techniques of psychotherapy, which themselves are open to attack for low improvement rates, often claim upwards of 31%.

"These rates are hardly grounds for celebration, particularly in the light of the uncertain criteria of improvement ... Behaviour modifying techniques regularly produce higher rates of improvement than this and without permanent damage to the human brain. Even standard psychotherapy, much maligned for poor rates of improvement, often does better than 31%. That the best results came from operations on young children is not surprising." 156

There is growing body of opinion which now feels that psychosurgeons grossly exaggerate good results, ignore side effects and even distort the outcome of treatment.

Perhaps the most damning aspect of the practice of psychosurgery is the lack of agreement among psychosurgeons on the site or size of the lesion

¹⁵⁶ Ibid.

¹⁵⁷ N. Melnick, "Violence curb via surgery goes to court", San Francisco Sunday Examiner and Chronicle, Jan. 6, 1974. Cited in J. Older, op.cit.

needed. Actually, psychosurgeons disagree not only on the lesion site and size, but also on the technique to be used, the nature of the psychiatric illness amenable to such procedures, the extent or format of follow-up studies, and the long term consequences of proposed operations. 158

Some practitioners themselves have viewed the current chaos with distress. British lobotomist Eric Turner pleaded with his colleagues for some order in arriving at diagnostic conclusions:

"A plea is made for accuracy of anatomical description of any operative procedures, and accuracy of psychiatric description of clinical states, even if this means abandoning sophisticated psychiatric terminology and limiting psychiatric description to a simplified but generally agreed nomenclature.

It is clear that in many cases different people have different conceptions of what is meant, for example, by aggression, paranoid schizophrenia or obsessional neurosis; so that this last diagnosis may be confused with involutional depression

^{157&}lt;sub>N. Melnick, "Violence curb via surgery goes to court", San Franciso Sunday Examiner and Chronicle, Jan. 6, 1974. Cited in J. Older, op.cit.</sub>

¹⁵⁸ Ibid., p. 35.

in a previous obsessional personality, a condition entirely different from a true obsessional neurosis and with an entirely different prognosis after frontal lobotomy." 159

Furthermore, psychosurgeons keep very sloppy records or none at all and have conducted few if any evaluative studies of their work. The existing data on surgical intrusion into the brain are inconclusive and contradictory at best. Elliot Valenstein, a proponent of psychiatric surgery, conducted a survey of the medical literature on the practice since 1971. He found that 56% of the published articles in the U.S. indicated that no objective tests were used by surgeons to evaluate the usefulness of the procedure. At the utmost only about 27% of psychosurgeons reported their results by writing articles on the outcome of the operations. Valenstein found that even the literature in fact produced by psychosurgeons had little scientific value:

¹⁵⁹ E. Hitchcock, L. Laitinen, K. Vaernet, eds., Psychosurgery: Proceedings of the Second International Conference on Psychosurgery, Springfield, Illinois, Charles C. Thomas, 1972, p. 209.

"the great majority of the psychosurgical literature has no scientific value and little validity. The possibility that a significant part of the improvement seen after surgery can be attributed to biased selection of patients and to 'placebo' effects cannot be ruled out. "160

Positive evidence as to the usefulness of psychiatric surgery is simply non-existent. Control groups are difficult to define, negative results are not systematically reported, and it is hard to evaluate persons still in institutionalized settings.

161 These problems are present in many forms of psychotherapy. However, the question of the scientific verifiability of psychosurgery assumes particular urgency as the procedure is irreversible.

Conclusion

The above data demonstrate that women are defined as mentally ill and placed in categories with no organic etiology more often than men. These

¹⁶⁰ E. Valenstein, "The Practice of Psychosurgery: A Survey of the Literature (1971-1976)," prepared for the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, June 11, 1976.

^{161&}lt;sub>W</sub>. Gaylin, et al., op.cit., p. 9.

categories, such as neuroses, are vague and uncertain.

Based on the initial diagnosis of neurosis, women are subject to gross physical treatments more often than men.

The treatments for neurosis, such as electroconvulsive therapy, chemotherapy and psychosurgery are
in widespread use. Their use entails the production
of dramtic side effects, and possible brain damage.
The negative effects of such treatment probably
outweigh any positive effects. Success rates are
invariably poor. Despite the disquieting evidence,
practitioners continue to practice and promote
physical psychotherapies.

Why, in the face of so much contradictory
data, do these dangerous therapies have such broad
acceptance? Why does it seem necessary to use maximal
surgical and chemical techniques on women with minimal
psychological problems? Why indeed are women
diagnosed as neurotic?

CHAPTER III

THEORETICAL PERSPECTIVES

Introduction

The differential diagnosis and treatment of females by psychiatry has been explained in several different ways. This chapter will critically discuss three major explanations which have been developed. The first model, the medical model of mental illness, presents a traditional psychiatric rationale for physical intervention in mental illness. The second and third models both provide critical analyses of mental illness definition and formation: labelling theory and feminism.

The Medical Model of Mental Illness

In this section I am concerned with psychiatry's self-conception. If it can be shown that psychiatry treats males and females differently it is imperative to consider the psychiatric account of this differentiation. In order to accomplish this task it is necessary to consider the root ideology of

traditional psychiatry. This ideology is the medical model of mental illness, which underpins the psychiatric processes of classification and treatment. I shall examine this model generally, and then as it considers the female.

The medical model of mental illness arises

from the analogy of mental disturbances and physical

ailments. Psychiatric practice is an adaptation of

the clinical model of medicine. This model takes the

individual physiology as the norm for pathology in

opposition to social conditions. It locates the source

of sickness within the individual's body. It is not

my intention here to elaborate on the clinical medical

paradigm, though it is worthy of note that the clinical

paradigm is open to critique on grounds of

individualism as is the psychiatric use of the medical

model. I intend mainly to focus on the contradictions

engendered by psychiatry's use of the medical metaphor.

Michel Foucault, The Birth of the Clinic: An Archaeology of Medical Perception, translated by A.M. Sheridan Smith, N.Y., Vintage, 1973.

Psychiatry, originally a branch of philosophy, merged with the clinical paradigm of medicine as it emerged in the 19th century. Just as clinical medicine locates disease within the individual, so psychiatry locates mental problems, defined as disease, within the individual. Clinical medicine is concerned with somatic disease, psychiatry is concerned with psychic disease. Dr. C.A. Roberts, as secretary of the Canadian Psychiatric Association and Chairman of the National Scientific Council of the Canadian Mental Health Association defines psychiatry as "the medical specialty concerned with diseases of the mind; psychiatrists are the medical specialists concerned with these diseases."

This paradigm of psychiatry has changed little since its inception. In 1844 in the second issue of the American Journal of Insanity, Amariah Brigham wrote

C.A. Roberts, Primary Prevention of

Psychiatric Disorders, Hunckey Memorial Lectures,

U. of T. Press, 1967.

"We consider insanity a chronic disease of the brain, producing either derangement of the intellectual faculties, or prolonged changes of the feelings, affections and habits of the individual."

In 1955 the American Psychiatric Association was told by R.W. Gerard: "When experience leaves an enduring trace, it must be some sort of material imprint; and, so to speak, there can be no twisted thought without a twisted molecule." The medical paradigm for psychiatry dictates the following features. First, the clinical description of behaviours as symptoms based on naturalistic observation. Second, a specific concept of disease, "neurosis", "psychosis", etc. Third, the elaboration of etiology and pathology confined to the individual. Finally the elaboration of a treatment based on medical forms - doctor-patient interaction based on

³Cited in Garfield Tourney M.D., "History of Biological Psychiatry in America", Amer. J. Psychiat. 126:1, July 1969, p. 30.

⁴R.W. Gerard, "The Biological Roots of Psychiatry", Amer. J. Psychiat. 112, 1955, p. 81, 90.

authority relations, physical therapies, hospitalization. ⁵

It is difficult to precisely outline the historical processes giving rise to the contemporary prominence of psychiatry. However, it is less difficult to demonstrate the ideological nature of psychiatry. The usage of the medical model of mental illness emphasizes individual dimensions of problems with a social etiology. The medical individual disease model has received criticism in the field of physical medicine itself. Its role in obscuring the social processes giving rise to individual distress is probably clearer in psychiatry.

Treatment for coping with various problem manifestations vary from problem to problem, and practitioner to practitioner. The common ground is the acceptance of the individual disease model.

"Some treatment programs concentrate on physiological strategies, including chemotherapy, and some

⁵Garfield Tourney M.D., op.cit., p. 29-42.

⁶V. Navarro, <u>Medicine Under Capitalism</u>, New York, Predisk, 1976.

stress psychotherapeutic interventions, but in spite of the surface rivalry and debate among adherents of specific techniques, the individual disease model provides a common frame of reference for all of them."

Psychosurgery is predicated on the idea that disturbed or disturbing behaviour results from a deranged mind which in turn results from a diseased brain. This idea took root first in the 19th century when mental disease was thought to be synonymous with brain disease. Pioneer lobotomist Burckhardt believed that "our psychological existence is composed of single elements, which are localized in separate areas of the brain." This type of logic is not so far removed from the logic of modern psychosurgeons who conduct a search for elusive brain cells which are the sites of specific behaviours.

Psychosurgeons still cling to this theory of

⁷H.L. Lennard, and A. Bernstein, "Perspectives of the New Psychoactive Drug Technology", in R. Cooperstock, ed., Social Aspects of the Medical Use of Psychotropic Drugs, A.R.R., Toronto, 1974, pp. 153-154.

⁸S.L. Chorover, "The Pacification of the Brain", op.cit., p. 60.

brain localization. Psychiatrist Frank Ervin and neurosurgeon Vernon Mark postulate in their book titled Violence and the Brain that over ten million Americans suffer from "obvious brain disease" and that the ghetto rebels of the sixties were victims of brain disease. They advocate screening the nation for people with "abnormal" brain waves in order to perform preventative psychosurgery on those whose brain waves indicate a predisposition towards violence. The psychosurgeons now point to "brain dysfunction" as the cause of urban rebellions. 10

The therapists themselves probably demonstrate most clearly the ideological bases for their work.

Peck believes in a biological etiology of neurosis-depression and he angrily inveighs against "starry-eyed reformers" who base their efforts on an "untrue hypothesis -- namely that mental illness is merely behavioral deviance and should not be treated medically

⁹V. Mark and F. Ervin, <u>Violence and the Brain</u>, N.Y., Harper and Row, 1970.

¹⁰ V. Mark and F. Ervin, <u>Journal of the American</u> Medical Association, 201, no. 11, Sept. 11, 1967.

... What they are proposing is revolution without viable alternatives." Peck continues: "I would not like to give the impression of being against social progress, I merely would like to make it clear that I do not believe that mental illness is caused by the lack of it." Peck sees society as stable and sane, and certain individuals as insane.

The theory of brain localization is not widely favoured among medical scientists. Most argue that there is no proof of any direct ties between specific brain abnormalities and corresponding behaviour disorders.

"No brain activity occurs in isolation, without correlated activity in other regions.

As the complexity of behavior increases, so does the extent of interaction in the brain.

Yet many psychosurgeons continue to ignore these facts, in favour of a pretentious and extreme doctrine of brain localization."

¹¹ R.E. Peck, The Miracle of Shock Treatment, N.Y., Jericho Press, 1974, p. 45.

¹²Ibid., p. 46.

¹³s.L. Chorover, "The Pacification of the Brain", op.cit., p. 69.

The individual disease model on which such theories develop, is based on a specific philosophy, the philosophy of individualism borne of the bourgeois revolution. The bourgeois rupturing of feudal social ties with the commodification of society and the introduction of the market, gave rise to the conception of the isolated individual. 14 For the bourgeois, society was no more than a conglomeration of isolated individuals, in competition with one another, motivated only by self interest. Society was in Hobbes' phrase, the bellum omnia contra omnes, 15 the war of all against all. However much of this social conception reflected the economics of the market place it did not and does not reflect the real basis of society, which is found in the relationships between individuals. The individual is not the minimum theoretical unit of society, the social relation is.

Georg Lukacs, <u>History and Class</u>
Consciousness, Cambridge, M.I.T. Press, 1972.

Thomas Hobbes, <u>Leviathan</u>, cited in Karl Marx, <u>Capital I</u>, New York, <u>International Publishers</u>, 1967, p. 617.

"Society does not consist of individuals, but expresses the sum of connections and relationships in which individuals find themselves." 16

and ignores the effects of the social whole, the changing social forces affecting the individual will be elusive. The reigning social order will be hypostatized and deviations from such order will appear to be abnormal, "sick" or "deviant".

Psychiatry is therefore prepared to buttress the existing order by defining all alienation or rebellion as illness and acting on that definition.

"Sociologists view psychiatry as among the 'mechanisms of social control' in contemporary society. It specializes in problems of control arising when individuals act in ways which don't fit with the institutionalized order." 17

Psychiatrists thus define mental health to accommodate the present social configuration. It serves

Karl Marx, <u>Grundrisse</u>, Harmondsworth, Penguin Books, 1973, p. 265.

Dorothy E. Smith, "Women and Psychiatry" in Dorothy E. Smith and Sara J. David eds., Women Look At Psychiatry, op.cit., p. 4.

to ideologically negate the existence of male chauvinism by defining problems caused by it (such as "neurosis" in housewives) as the result of individual illness. So, women's problems are self-inflicted!

"Whether it be the 'neurotic' housewife, 'acting out' pupil, or the 'paranoid student radical', therapy has become a central ideological instrument for obscuring people's understanding of their experience and for preventing their recognition of the social bases and collective nature of their oppression. It does this by reducing collective experience to a sum of individual experiences and by reducing all social grievances to individual pathology. 18

Some of the contradictions inherent in the attempt to mask social problems with individual pathology appear in the fact that psychiatry has never quite been able to make itself look like "physical" medicine. Psychiatrists do not diagnose their patients like other doctors do. They discard four of their senses and literally play it by ear. Physical examination and laboratory investigation, which

M. Glenn and R. Kunnes, Repression or Revolution?, N.Y., Harper and Row, 1973, p. 56.

transformed medicine from guess-work and theory to fact and science, are avoided or discouraged.

Psychiatric "illness" supposedly results from non-specific stress acting upon the presumed predisposed. The patient is then characterized by epithets which insult his intelligence and personality. The "disease" process supposedly at work is denied by the therapist in describing the patient in terms such as "will not" eat, cooperate, etc. "Physical" doctors would ask why the patient can not do these things. No other specialty blames illness, and therapeutic failure, on patients. Psychiatrists ask their subjects questions such as "why are you depressed?", whereas nobody would ask a patient why he suffered from, say, pneumonia, or put a large amount of credence on what was volunteered as the cause. In fact, some psychiatrists recognize the differences between psychiatric and "physical" medical practice:

"The criteria for medical disease are physicochemical while the criteria for psychiatric disease are social and ethical. To diagnose and treat physical disorders we use methods of physics and chemistry.

To identify and eliminate mental disorders we use methods of social communication, evaluation and influence... Every medical specialty except psychiatry has in common an ultimate interest in the structure and function of the human body as a physicochemical machine. Psychiatrists, on the other hand, are interested in, and intervene in, human conduct and social processes..."19

Although the disease model is the basis of psychiatric theory, practice demonstrates that therapists broadly depart from accepted procedure associated with this model. Thus, behind the ideological screen provided by the medical model, ²⁰ psychiatrists can use a wide range of methods to force/persuade the subject to conform to the psychiatrist's conception of proper behaviour.

The definitions employed by psychiatrists differ greatly from those used by physical doctors.

This is inevitable inasmuch as psychiatrists attempt to define moral and political problems medically.

R. Leifer, "The Medical Model as Ideology", Int. Journ. Psychiat. 9, 1970, pp. 13-21.

²⁰ Ibid.

Take for example the definition of "neurosis". One psychotherapist as previously stated, defines neurosis as follows:

"A psychological disorder often characterized by (1) sensory, motor, or visceral disturbances, (2) anxiety, (3) troublesome thoughts, (4) sleep disturbances, (5) sexual disturbances, (6) general inhibition. Reality contact remains similar to that of the community."²¹

Another has a more personalized definition:

"A general term covering a group of conditions characterized by unreasonable emotions such as anxiety, depression, and various physical symptoms thought to be functional. Actually most neuroses probably have a foundation in an autonomic nervous system dysfunction."22

One could continue providing as many different definitions as there are practitioners. One thing must be noted however, and that is the vagueness of the definitions offered. Given the lack of physiological indicators, the therapist must rely for

Hans H. Strupp, <u>Psychotherapy and the Modification of Abnormal Behaviour</u>. N.Y., McGraw-Hill, 1971, p. 190.

R.E. Peck, The Miracle of Shock Treatment, N.Y., Jericho Press, 1974, p. 70.

diagnosis on purely subjective factors. The doctor must decide whether the patient's emotions are "unreasonable", or what status to accord the patient's "troublesome thoughts". These decisions then become "diagnoses" and the doctor's standards of health and illness, normality and abnormality accord with the status quo. 23 The rebel or the alienated person will be seen as "sick".

Perhaps the most telling differentiation
between "mental" and "physical" medicine is the
astonishing variety of treatments given to the same
diagnostic category. For example, many psychosurgeons
believe that the best treatment for "neurotics"
(however defined) is the surgical induction of a
lesion - in the brain. However, the psychosurgeons
will operate on different sites in the brain, in
totally different cerebral structures, will create
different sizes of lesion and will use different
surgical tools. They disagree on the type of patient
amenable to such procedures, the nature of follow-up

²³See Dorothy E. Smith, op.cit.

studies and the long term results of the operations.

None will deny the need for surgery or its beneficial effects however. Psychosurgery is only one technique of psychotherapy, and the chaos over the entire field is unimaginable. I would postulate that the psychiatric profession is allowed such astonishing leeway because of the ideological service it performs in preserving the status quo for the present social formation.

How does psychiatry itself account for psychiatric sex differentiation? Given psychiatric support for the status quo, one would expect psychiatry to incorporate patriarchal ideology. The starting point here is the psychiatric view of women.

Psychiatry ascribes the following traits to

²⁴ See Samuel Chavkin, op.cit., p. 35.

²⁵ It should be noted throughout this paper that for my purposes psychiatrists are the instrumental human forms for psychiatry. While I recognize strains and conflict within the profession, I believe that one may talk of psychiatry just as one may talk of law, to signify the traditional streams in the discipline. Laing's self label as an "antipsychiatrist" recognizes the orthodox connotations of "psychiatry".

women:- they are attracted to suffering²⁶; they are naturally motherly²⁷; they are mysterious²⁸; they perceive men as dominant and strong. Furthermore, the woman is "masochistic, ... an attitude toward life in which the individual uses weakness and dependency as a means of controlling others and gaining safety in life."²⁹ Parsons and Fox³⁰ state that a woman uses illness as a "compulsively feministic way of reacting to her exclusion from the life open to a man". "Nagging" is the "typically feminine regressive way of dealing with internal excitement."

Popular psychiatrist and author Bruno

Helene Deutsch, The Psychology of Women: A Psychoanalytic Interpretation, N.Y. Grune and Stratton, 1945.

²⁷ Ibid.

²⁸ Ibid.

M. Komarovsky, Women in the Modern World:
Their Education and Their Dilemmas. Boston: Little,
Brown and Co., 1953, p. 37.

³⁰T. Parsons and R. Fox, A Modern Introduction to the Family, N.Y., Free Press, 1968, p. 562.

J. Kestenberg, "Nagging, Spreading Excitement, Arguing", International Journal of Psychoanalytic
Psychotherapy, vol. 2, #3, 1973, p. 265.

Bettelheim writes that:

"We must start with the realization that, as much as women want to be good scientists or engineers, they want first and foremost to be womanly companions of men and to be mothers."32

Harvard Medical School psychiatrist, Joseph Rheingold reworks the "anatomy is destiny" theme:

"Woman is nuturance...anatomy decrees the life of a woman... when women grow up without dread of their biological functions and without subversion by feminist doctrine, and therefore enter upon motherhood with a sense of fulfillment and altruistic sentiment, we shall attain the goal of a good life and a secure world in which to live it."33

While these personality traits appear in total to be singularly unappealing, psychiatrists view them as the foundations for mental health in females. Deviations from this constellation of

Cited in Weisstein, N., "Psychology Constructs the Female" in V. Gornick and B.K. Moran (eds.) Woman in Sexist Society, op.cit., p. 207.

³³ Joseph Rheingold, The Fear of Being a Woman, N.Y. Grune and Stratton, 1964, p. 714.

characteristics are viewed with alarm by the therapists as evidence of sickness.

"In fact, any deviations from the norm of 'feminity' are regarded with a good deal of disfavour, and are associated with underlying neurotic disturbance. It is not right for women to have manlike qualities, and the woman who does, or who deviates from her role of wife and mother in any way is labelled in varying degrees, as pathogenic." 34

Thus, while a woman is allowed to be "maso-chistic" or "compulsively feministic", if she is competitive, aggressive, disobedient or career oriented she is exhibiting possible symptoms of sickness. In a study of clinicians by Dr. Inge K. Broverman, 79 psychiatrists (46 male and 33 female) were asked to complete a sex-role stereotypic questionnaire. This questionnaire contained 122 items describing character traits in bipolar terms, for example,

³⁴Dorothy E. Smith, "Women and Psychiatry" op.cit., pp. 22,23.

"very subjective....very objective not at all aggressive..very aggressive" 35

The clinicians were asked to typify the various behaviours listed in terms of "healthy male", "healthy female" or "healthy adult". Significantly, there was near unanimity among the clinicians as to what constituted "healthy" male, female or adult characteristics. It is of equal significance that there were no important differences between male and female clinicians in their evaluations. They all describe "healthy" female or male characteristics in highly stereotypical terms.

"... clinicians are more likely to suggest that healthy women differ from healthy men by being more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, having their feelings more easily hurt, being more emotional, more conceited about their appearance, less objective, and disliking mathematics and science. This constellation seems must unusual way of describing any mature, healthy individual." 36

Inge K. Broverman, et al., "Sex-Role Stereotypes and Clinical Judgements of Mental Health", Journal of Consulting and Clinical Psychology 34, #1, Feb. 1970, p. 5.

³⁶ Ibid.

It is on the basis of such sex discriminatory theories that psychiatrists diagnose and treat women who do not appear "normal". These treatments include electroshock, chemotherapy and psychosurgery.

In fact, surgery has long been used as a solution to social management problems. Medicine has always been careful to obscure its social management function with scientific "medical" terminology. In the ante-bellum slave owning South of the United States Dr. Samuel Cartwright of Louisiana diagnosed the malady of slaves who had the strange compulsion to escape the plantations. He discovered that such slaves suffered from "drapetomania", literally "flightfrom-home madness". This, of course, was "as much a disease of the mind as any other species of mental illness". The Cartwright also unearthed "dysaesthesia Aethiopica" (peculiar to black people) an ailment wherein these afflected would "pay no attention to the rights of property ... slight their

A. Thomas and S. Sillen, Racism and Psychiatry, Secaucus, N.J., The Citadel Press, 1974, p. 2.

work ... raise disturbances with their overseers."38a Having, thus named the disease, Dr. Cartwright formulated the obvious surgical cure at the site of the malfunction. The treatment for the "running-away disease" was to surgically remove the patient's toes.

The surgical oppression of slaves is clearly analogous to the modern surgical oppression of women, and others who lack power. The point of departure for the medical theorists in both cases is the identity of docility and health, and conversely of protest, in whatever form, and illness. The exact function of the surgeons as instruments of social, rather than medical control is made opaque by the invention of impenetrable scientific terms to describe the "disease" -
"dysaesthesia Aethiopica", "dyscontrol syndrome",

"minimal brain dysfunction", "pseudo-neurotic psychosis" etc. The treatments have a striking continuity. The toes of runaway slaves are amputated, and parts of the brain tissue of women who do not "fit in" are surgically destroyed.

³⁸a Ibid.

Psychiatry operates by incorporating the sex role division imposed by patriarchy into its definitions of mental health or illness. When women conflict with the role demands of male chauvinsim, when they question their positions as housewives, mothers, or sex objects, psychiatrists define this conflict in terms of illness. By so doing they obscure the contradictions and oppression generated by sex discrimination. They in fact, reinforce this discrimination by blaming the victims of oppression (women) for the effects of oppression (contradictions in the female role). In so doing, psychiatrists fall into step behind the nineteenth century ideologues (including Freud) who saw frailty, sickness and hysteria as "female traits". 38b

In conclusion the medical model of mental illness attempts to find the source of alienation and and problematic behaviours within the individual

See Ben Barker-Benfield, "Sexual Surgery in Late Nineteenth Century America" in International Journal of Health Services, vol. 5, #2, 1975, pp. 279-298, Sigmund Freud, Case of Dora: An Analysis of a Case Hysteria, N.Y., W.W. Norton, 1952.

abstracted from the social environment. Because of its unwillingness to confront the social contradictions which motivate "neurotic" behaviour, psychiatry upholds the status quo. The patriarchal prescriptions for female behaviour are the psychiatric definition of normalcy.

Labelling Theory

In examining the differential psychiatric diagnosis of females it is necessary to confront labelling theory. Labelling theory is a critique of the medical model of mental illness and could provide a basis for a consideration of psychiatric sex bias. Inasmuch as labelling theory comprehends the process of defining the prospective patient, it could provide a theoretical model of the psychiatric choice of subject by sex. What follows here however, is a critical discussion of the basis of labelling theory with regard to psychiatry.

Labelling theory has criticized the medical model of mental illness by asserting that "ill" behaviour is more a consequence of the social labelling process than of organic disease.

The labelling theory approach to the study of "deviance" grew as a reaction to the simplistic acceptance of orthodox theories by traditional sociology. The labelling school rejected the earlier notion that mental illness and criminality were genetically based. It rejected the rationalistic conception that "deviant" acts were inherently "sick" or "criminal", i.e. injurious to society generally. Instead the labelling theorists focussed on the manner in which a person's actions came to be considered deviant as a result of being labelled as such. 39

The labelling school is also known as the "societal reaction" school because of its emphasis on societal reaction as the generator of deviance. The

³⁹ See Edwin Lemert, Social Pathology, N.Y.
McGraw-Hill, 1951; Edwin Lemert; Human Deviance, Social
Problems and Social Control, N.Y., Prentice-Hall, 1967;
Earl Rubington and M.S. Weinberg (ed.) Deviance:
The Interactionist Perspective, N.Y. Macmillan, 1968;
Erving Goffman, Stigma, Englewood Cliffs, N.J.,
Prentice-Hall, 1963; Erving Goffman, Asylums,
Garden City, N.Y., Doubleday, 1961; Thomas J. Scheff,
Being Mentally Ill: A Sociological Theory, Chicago,
Aldine 1966, among others.

main focus of labelling theorists is on what they
perceive to be two distinct phases in the creation of
the "deviant". First, the production of "primary
deviance". Primary deviance is the initial behaviour
process which causes the individual to come to
"society's" attention and be labelled deviant.
According to Lement, primary deviance is

"...assumed to arise in a wide variety of social, cultural and psychological contexts, and at best to have only marginal implications for the psychic structure of the individual: it does not lead to symbolic reorganization at the level of self regarding attitudes and social roles."

Labelling theorists concentrate their attention more on the second part of this process, whereby the reaction of society causes the labelled individual to accept his stigmatized role, and concomitantly alter his self-image. Lement states that secondary deviation should be viewed as

"deviant behavior, or social roles based upon it which becomes a means of defense,

Lemert, Human Deviance, Social Problems and Social Control, op.cit., p. 17.

attack or adaptation to the overt and covert problems created by the societal reaction to primary deviation."

Labelling theorists see a sharp disjunction between primary and secondary deviation. Since everyone at some time commits acts which could be labelled deviant, the process leading to the initial act, its observation and labelling are less important than the ongoing stigmatization process which leaves the individual to re-examine himself and re-cast his personality in the deviant role. The primary deviation may be caused by countless factors, the secondary deviation is the result of labelling or societal reaction. In fact, as Lemert puts it

"In effect, the original causes of the deviation recede and give way to the central importance of the disapproving, degradational and labelling reactions of society."42

Among the limitations of the labelling approach are that: it fails to ask the key question -- "Who

⁴¹ Ibid.

⁴² Ibid.

defines the labels and why?"; it concentrates on the wrong problem, the act of labelling as opposed to the broader social processes resulting in this act; it ignores the question as to why problem behaviours initially arise, i.e. are people "driven crazy" or is this just a definitional problem?; and the approach is ahistorical. It may be objected that some labelling theorists actually do touch these questions. Becker, 43 for instance, recognizes that society is shaped by powerful interest groups which enforce the deviant label on subordinate groups. However this observation is not developed in his work, nor is it rigorously integrated into an holistic analysis of the problem. Similarly $\operatorname{Szasz}^{44}$ (who may loosely be regarded as a labelling theorist) recognizes the changes in definitions of madness through historical epochs. He never defines these epochal revolutions as a consequence of changes in the mode of production. Furthermore he

⁴³Howard S. Becker, "Whose Side Are We On?" in Social Problems, 14, 1967, pp. 239-247.

Thomas S. Szasz, The Manufacture of Madness, N.Y. Harper and Row, 1970.

maintains that problems lie in the "concept" of mental illness, alone.

At its most basic, labelling theory suffers from philosophical idealism. It regards the idea/ label as the progenitor of the reality/deviant behaviour. At best this relegates the exploration of the social context of the discovery of deviance to second place, at worst it ignores it altogether. Since the label creates the behaviour, why be concerned with the social contradictions which generate the behaviour and make it problematic? The labelling approach seems to deny the possibility that the contradictions of life in capitalist society do create strains which drive people "crazy", which cause them to react in problematic, or self-destructive ways.

For a detailed critique of the idealism of labelling theory, see Bob Fine "Labelling Theory: an investigation into the sociological critique of deviance", Economy and Society Vol. 6, 1977, pp. 166-193. Fine enters into an intricate analysis of labelling theory treating it as three separate theories. Fine's perspective is that, despite the critique of positivism, labelling theory is uncritical positivism.

Labelling theory could comprehend psychiatric sex discrimination as a natural result of the labelling of deviant women, or it could see this process of labelling as conditioned by the subordinate position of women a la Szasz. However, by concentrating on the act whereby the distressed woman is labelled "neurotic", labelling theorists negate the social contradictions generating her distress. Furthermore, they fail to explain why the psychiatrist also ignores the social component of this distress and reduces it to individual symptomatology. Labelling theory may provide an interesting partial critique of the selective mechanisms by which psychiatry labels women and imprisons them within the label, but it goes no further. Interestingly enough in this respect labelling theory is guilty of the very sin it attacks, by using the terminology of "deviance" to describe those caught in the labelling process it further stigmatizes those so labelled. In rejecting the medical model of mental illness, or the traditional model of criminology, the labelling theorists move too They deny the existence of individual behavioural problems relative to particular social formations.

Instead they see the problem solely in the idea or the label. This is relativistic idealism which assumes that there would be no deviance without labels.

In order to argue that "the label is all", labelling theorists point out that the same action may be deviant or normal depending upon the perception of the act by others. A famous example is that of killing in war and killing in peace time. 46 One is acceptable behaviour, the other deviant. However, the perceptions of significant others are based upon material reality: the social contexts of the acts. It is the social context which gives an act meaning. The problem becomes the analysis of the social construction of reality. Who has the power to situate acts as deviant or normal?

The labelling theorists necessarily flounder in having to explain the chain of causation leading to the primary deviance. The question of what behaviour

See I. Taylor, P. Walton, and J. Young, <u>The New Criminology:</u> For a Social Theory of Deviance,
N.Y. Harper and Row, 1974, pp. 139-171 for an outline and critique of labelling theories.

leads to "labelling" and of who precisely does the labelling are unfathomable. Lemert more or less says as much: the roots of primary deviation are too complex to study. Primary deviation is "polygenetic, arising out of a variety of social cultural, psychological and physiological factors." In any event the problem of secondary deviation is "pragmatically more pertinent for sociology than primary deviation". For Scheff, who sees primary deviation as "rule-breaking", the causes of initial rule-breaking assume minimal or no importance after labelling occurs. Scheff finds initial rule-breaking too vague to study in any event. Any sort of ill-defined "residual-rule", expectation or norm may be broken and lead to labelling.

"When societal agents and persons around the deviant react to him informly in terms of the traditional stereotypes of insanity, his

⁴⁷ Cited in I. Taylor, op.cit., p. 159.

Lemert, Human Deviance, Social Problems and Social Control, op.cit., p. 18.

⁴⁹ Thomas Scheff, Being Mentally III, Chicago, Aldine Press, 1966, pp. 50-54.

amorphous and unstructured rule-breaking tends to crystallize in conformity to those expectations, thus becoming similar to the behavior of other deviants classified as mentally ill, and stable over time. The process ... is completed when the traditional imagery becomes a part of the deviant's orientation for guiding his own behavior."50

This leaves the sociologist in a nice compact world where the "deviant" is already in the hands of the "authorities" who together may plan out his deviant career. The thornier questions of how and why the individual arrived in such a position, and more importantly how and why the authorities came to be authorities with power, remain unasked.

I should perhaps qualify an earlier statement. I said that labelling theorists fail to ask "who does the labelling?" In fact they make an attempt at this question, but fall far short of the answer. Since they follow the interactionist school of G.H. Mead 51

⁵⁰ Thomas Scheff, op.cit., p. 79.

⁵¹ George H. Mead, Mind, Self and Society, Chicago, University of Chicago Press, 1934.

they see society as a myriad of interacting individuals who affect each others' self images. The labellers can only then see as far as the nearest interacting actor. For the criminal, it is the policeman, for the neurotic, it is the psychiatrist. This approach evolves some interesting critiques of the police and of psychiatry (Goffman⁵²), but is unable to integrate these insights into an encompassing theory of social structure. The question "who governs the governors?" lurks in the background, unasked. When these questions are gingerly approached the labelling theorists eschew such categories as "class" as doctrinaire. Lemert says:

"it is doubtful that procedures for defining deviance can be laid to the creations of any one group, class or elite. Rather they are the products of the interaction of groups." 53

This leads one to ask where the interacting

⁵² E. Goffman, Stigma, op.cit.: E. Goffman, Asylums, op.cit.

⁵³ Edwin Lemert, "Beyond Mead: The Societal Reaction to Deviance", Social Problems, Vol. 21 #4, 1974, p. 462.

groups receive their definitions of reality. Lemert must be accused of idealism since he endows interacting groups with the power to spontaneously evolve ideas, labels, etc. which can then miraculously be transformed into social norms, presumably.

When the labelling theorists then discover that the powerless and poor are defined as criminal or mentally ill one can further this discovery by incorporating it into the context of the class struggle. It follows from this point that the "powerful" do not arbitrarily select members of the "powerless" groups for special treatment. The labelling is not an ad hoc process. In fact the concepts of "deviance" and the deviant population change over time, in accord with the changing structure of society. Labelling theorists fail because of their ahistorical approach. They cannot answer why, at this particular juncture group A is deviant as opposed to group B. For example, Szasz specifically suggests that psychiatry chooses its victims from among the "powerless" - women, blacks,

⁵⁴ August B. Hollingshead and Fredrick C. Redlich, Social Class and Mental Illness, N.Y., John Wiley, 1958.

poor people. He is however, unable to describe why psychiatry so victimizes people except to state that the victimizers are powerful and the victims powerless. He instead points to an overarching, ahistorical and universal need to persecute "The Other" in order for society to sustain a positive self image through the expulsion of evil. ⁵⁵ The scapegoat is eternal.

One other criticism which has been levelled against labelling theorists must be considered. That is the class bias of the labelling school. This school has been accused ⁵⁶ of concentrating solely on the deviance of the oppressed in society, not on middle class deviance or the deviance of the oppressors.

This has led to an overemphasis on a study of segmental social outcasts, the outsiders, the "nuts, sluts, and preverts." This criticism implies that the labelling

⁵⁵ Szasz, op.cit.

Alex Thio, "Class Bias in the Sociology of Deviance", The American Sociologist, vol. 8, Feb. 1978, pp. 1-12, Alexander Liazos, "The Poverty of the Sociology of Deviance: Nuts, Sluts and Preverts", Social Problems, 20 #1, 1972, pp. 103-120.

⁵⁷A. Liazos, op.cit.

school could improve simply by altering the focus of its research. However, the central notions of societal reaction theory, its interactionist bases are still problematic. It is not merely a matter of preference for the labelling theorist to exclude middle class deviants from his field of study. Indeed labelling theory itself forces the theorist to take this course. Since middle class people do not generally tend to be labelled "deviant", how can the labelling theorist consider them?

In essence labelling theory is a liberal reaction to traditional theories of mental illness and criminology. It is possibly inspired by the marginality of the academic and his empathy for other marginal groups in society. ⁵⁸ It sees society as a plurality of competing groups, with powerful groups able to impose their definitions of reality on the less powerful. However it is basically astructural, ahistorical and non-comparative. It is unable to define the power

N.J. Davis, The Sociological Construction of Deviance, Dubuque Iowa, W.C. Brown, 1975, pp. 164-191.

groups clearly in class terms. It is further unable to examine the processes which produce the distressed, rebellious or alienated behaviours which become labelled. 59

Feminism

The modern feminist movement has confronted the problem of the differential diagnosis and treatment of women in medicine and psychiatry. It has avoided certain of the limitations of labelling theory.

Feminism places the treatment of women by psychiatry firmly within a broad social and political context.

This context is the oppression of women by patriarchal society. Feminism comprehends the processes which cause women to react in alienated, "neurotic" ways.

It understands these processes not merely as a consequence of labelling, but as a consequence of the contradictory role demands which male chauvinism makes on women. Furthermore feminism views psychiatry as part of the apparatus of male chauvinism.

Because feminism is a broad theoretical

See I. Taylor, et al., op.cit. for a good Marxist critique of labelling theory.

appreciation of sex discrimination in all spheres of society, I intend to move from a general discussion of feminism to specifics. That is, I believe it necessary to examine the basic theoretical constructs of feminism before moving to a specific discussion of the feminist view of psychiatric sex bias. In examining feminist theory in general, I shall critically evaluate three seminal feminist thinkers:

Kate Millett, Shulamith Firestone, and Juliet Mitchell. Following this I shall discuss feminists who have examined patriarchal psychiatry, such as Phyllis

Chesler and Dorothy E. Smith.

At the outset it must be noted that the emergence and vitality of modern feminism has been of great significance. It has undermined traditional male chauvinism and it has done much to remind socialists of their responsibilities in the struggle for the liberation of women. However, feminism has remained theoretically flawed by idealism and ahistoricism. The feminists' prime mistake has been to separate the class and women's struggles. They have located the heart of women's oppression within

the family and "patriarchy". This has left the feminists confronted with universal sex oppression and with few prospects for undermining the foundations of this oppression. I would argue that the basis of sex oppression lies in the historical dynamic of the class struggle. This perspective not only explains the changes in the nature of sex oppression over time, it also demonstrates how the contradictions of capitalism in the 1960's gave birth to feminism itself. That is, feminism is located within the class struggle, not in any autonomous region of "patriarchy".

One of the earlier and more popular of the feminist authors is Kate Millett. Millett's work is much cruder than that of later writers. She in fact does little more than describe the problem. Millett's theoretical formulae are simplistic dogmas, men oppress women because they control everything and benefit by it. The basis for this oppression is the family which is dominiated by the male. Millett does not ask why this oppression occurs. Millett denies the centrality

Kate Millett, <u>Sexual Politics</u>, N.Y. Doubleday, 1970.

of class and affirms the centrality of the patriarchal family by asserting that patriarchy is embedded in psychic structures which outlive revolutionary changes. The patriarchal family is so fundamental to society that

"a referent scarcely exists with which it might be contrasted or confuted. While the same might be said of class, patriarchy has a still more tenacious and powerful hold through its successful habit of passing itself off as nature." 61

Revolutions do not eradicate women's oppression because they leave "the socializing process of temperament and role differentiation intact." The consciousness of sex differentiation is simply deeply rooted in the consciousness of humanity itself:

"...the arena of sexual revolution is within the human consciousness even more pre-eminently than it is within human institutions. So deeply embedded is patriarchy that the character structure it creates in both sexes is perhaps even more a habit of mind and a way of life than a political system." 63

⁶¹ Kate Millett, Cited in Elizabeth Fee, "Women and Health Care: A Comparison of Theories", International Journal of Health Services, vol. 5 #3, 1975, p. 402.

⁶² Ibid.

⁶³ Ibid.

Habits of mind are elusive things to conquer, especially when the population is dominated by a patriarchal government, "the institution whereby that half of the populace which is female is controlled by that half which is male." The only ill-effects of the intrusion of class into this picture, according to Millett, is that it obstructs the unity of women against the real enemy, men. "One of the chief effects of class within patriarchy is to set one woman against another."

Although Millett is admittedly less sophisticated than her successors, the central threads of feminist theory have been drawn out in her work. The oppression of women supercedes class oppression. Class occurs "within patriarchy". The battle of the sexes is the larger arena within which the class struggle is a skirmish.

Shulamith Firestone developed this perspective more clearly. 66 The biological division of sexes is the

⁶⁴K. Millett, op.cit., p. 25.

⁶⁵ Ibid., p. 38.

Shulamith Firestone, The Dialectic of Sex, N.Y. Bantam, 1970.

earliest and most important division in human society. The sex class system is universal and inherent in the biological family. Firestone views male domination in the family as the origin of all class systems, and the patriarchal family, the basic unit of all class societies, and male dominated societies. The "dialectic of sex", not class, moves society. The imbalances of power in the biological family between women and men, children and adults, result in "power psychology", a "psychological pattern of dominance-submission". 67

Firestone attempts to provide the answer to
the question Millett could not answer, that is, why do
males dominate? Firestone openly accepts the
patriarchal doctrine that biological differences are
at the root of women's oppression. Women become
pregnant and are responsible for child care and this
leads to the first division of labour. The biological
family is the institutional form for this division of
labour. Thus the task of the revolutionary was to
overthrow Nature itself:

⁶⁷ Ibid., p. 149.

"For unless revolution uproots the basic social organization, the biological family - the vinculum through which the psychology of power can always by smuggled - the tapeworm of exploitation will never be annihilated. We shall need a sexual revolution much larger than - inclusive of - a socialist one to truly eradicate all class systems."68

The sexual revolution, the overthrow of nature, will be accomplished by technological means. The biological underpinning of women's oppression would be removed by 'overthrowing' pregnancy by means of artificial fertilization and test-tube babies.

Firestone's importance lies in her acceptance of socialism, her problems lie in her ahistorical discussion of sex oppression and her utopian solutions.

Firestone came under fire from socialist
feminist, Juliet Mitchell, in her work "Women's Estate".

Mitchell criticizes Firestone for her assertion that

sex oppression presaged all other oppression. Mitchell

points out that sex relations are specific to specific

⁶⁸ Ibid., pp. 11, 12.

⁶⁹ Juliet Mitchell, Women's Estate, N.Y. Pantheon, 1971.

societies, i.e. they do not exist in general.

"To say that sex dualism was the first oppression and that it underlies all oppression may be true, but it is a general, non-specific truth, it is simplistic materialism, no more. After all we can say there has always been a master class and a servant class, but it does matter how these function (whether they are feudal landlords and peasants, capitalists and the working class and so on); there have always been classes, as there have always been sexes, how do these operate within any given, specific society." 10

Mitchell also criticizes Millett for assuming that patriarchy was a universal political system under which the economy was subsumed. "...a political system is dependent upon (a part of) a specific mode of production: patriarchy, though a perpetual feature of it, is not in itself a mode of production though an essential aspect of every economy, it does not directly determine it." Mitchell retreats from these criticisms in her later work Psychoanalysis and

⁷⁰Ibid., p. 87.

^{71&}lt;u>Ibid.</u>, p. 83.

Feminism⁷² in which she resurrects patriarchy as a parallel social determinant to the economic mode of production.

The seeds for Mitchell's retreat into the patriarchy thesis were sown in <u>Women's Estate</u>. In this book she argues for the dichotomy of psychology and economy. Human psychology, the link between biology and society through the family, is the theoretical province of psychoanalysis, the economy is the province of marxism.

"The bio-social universal, the ideological atemporal, the economic specificity all interlock in a complex manner... Psycho-analysis, the scientific method for investigating the first, can be neglected no more than scientific socialism for understanding the last, the economic, and both are needed for developing a comprehension of the ideological." 73

This understanding seems to conflict with

Mitchell's earlier statement that the family was

"embraced by production (the man's world) - precisely

Juliet Mitchell, <u>Feminism and Psychoanalysis</u>, London, Allen Lane Press, 1974.

⁷³ Juliet Mitchell, <u>Women's Estate</u>, <u>op.cit.</u>, p. 167.

a structure that in the final in stance is determined by the economy. "74 Mitchell's confusion about the roles of psychoanalysis and scientific socialism in demarcating specific areas for analysis leads her to the total separation of patriarchy and capitalism in Psychoanalysis and Feminism. In this work the determinant in the final instance has ceased to be the economy. Mitchell returned to Firestone's bifurcation of sex differentiation and class conflict. Eli Zaretsky incisively saw the direction in which Mitchell was tending in his discussion of "Women's Estate": 75

"Mitchell's formulation threatened to reproduce the very dichotomy between socialism (the economy) and feminism (the family) that she criticised so well". 76

Mitchell's analysis in <u>Psychoanalysis and</u>

<u>Feminism</u> starts from the assumption that patriarchy
is an ideological mode and capitalism an economic mode.

⁷⁴Ibid., p. 148.

Personal Life, N.Y., Harper and Row, 1973.

⁷⁶Ibid., p. 22.

Both "modes" are autonomous:

"To put the matter schematically, in analyzing contemporary Western society we are (as elsewhere) dealing with two autonomous areas: the economic mode of capitalism and the ideological mode of patriarchy."

For Mitchell, patriarchal ideology does not arise on the base of class relations, but is part of an ahistorical continuity of the unconscious. The unconscious can only be studied by psychoanalytic science, which can analyse its elements, language, patriarchy, etc. These elements form "culture" which produces unconscious forms. Psychoanalysis understands this unconscious cultural transmission apart from historical contexts. Mitchell does not believe that Marxism is able to accomplish the task of analysing patriarchal culture. She rejects the notion that capitalism is a structured whole "articulated in dominance" as Althusser would have it. So therefore capitalism "does not in itself provide the object of

Juliet Mitchell, <u>Psychoanalysis and Feminism</u>, op.cit., p. 412.

Touis Althusser, "Contradiction and Overdetermination", in Louis Althusser, For Marx, N.Y. Vintage Press, 1970, p. 202.

scientific study."⁷⁹ Marxism does not, despite all claims, study capitalism, but only "its defining feature ... the nature of its particular class relations."⁸⁰

Mitchell views the patriarchal system as autonomous, with its own origins and development. She argues that the basis for patriarchy is found in kinship systems. These systems authorized the exchange of women between families giving rise to the incent taboo. Mitchell ties this concept into psychoanalysis by asserting that the Oedipal complex receives its origins in the prohibition against incest. Mitchell then argues that the kinship and patriarchal laws are universal. "Sexual laws are... the equivalent of inter-human communications and coexistent with society itself." Patriarchy "is a question neither of biology nor of a specific society, but of human society itself." Mitchell adds a point common to all feminist

⁷⁹ Juliet Mitchell, <u>Psychoanalysis and Feminism</u>, op.cit., p. 258.

⁸⁰ Ibid.

⁸¹ Ibid., p. 373.

⁸² Ibid., p. 409.

arguments indicating the separateness of sex and economy: sex oppression existed before capitalism and even after socialist revolution:

"The longevity of the oppression of women <u>must</u> be based on something more than conspiracy, something more complicated than biological handicap and more durable than economic exploitation (although in different degrees all these may feature).83

I do not propose to launch a critique of structuralist anthropology or of psychoanalysis. That is beyond the purpose of this thesis. I do wish to criticize the ahistoricism of feminist thought, and the separation of the realms of sex oppression (located by feminists in the family and related structures such as kinship systems) and the economy. In essence these feminist thinkers have a continuity of themes. Firstly the almost immutable nature of differences between males and females. Secondly the fact that patriarchy has had remarkable staying power, and lastly that sex oppression is not determined by the class struggle.

The danger of a reduction to biological

⁸³ Ibid., p. 362.

determinism lurks in these feminist theses. Even
Mitchell, who claims to have expunged biology from
her thesis in favour of culture as a determinant, has
failed to eliminate the possibility of reading
biological determinism into her paper. Mitchell's
problem in this respect is her acceptance of the
"exchange of women", and "Oedipal" theses. For the
former, although Mitchell posits that the exchange of
women and subsequent incest taboo generated patriarchal
culture, she nowhere explains why this happened, i.e.
why men were not exchanged.

"... there is a theoretical reason why women should not exchange men, but empirically this has not taken place in any human society... there must be available a theoretical explanation of why it does not happen."84

Mitchell is unable to adduce this explanation and thus the back door is left gaping for biological explanations to enter. Similarly the Oedipal complex thesis rests on an original domination of woman by man. Without the historical explanation for this eschewed

⁸⁴ Ibid., p. 372.

by Mitchell, her conclusion must be that the sociocultural distinctions between man and woman rest on a biological foundation. 85 Anatomy is indeed destiny.

Ann Foreman makes this explicit:

"On top of this, however, in dismissing a social and historical explanation of that relation the Oedipus complex rests on a biological one. In other words, Mitchell's adherence to the Oedipus complex leads her to the conclusion that the social and cultural distinctions between men and women are ultimately reducible to biological differences."

The difficulty which these feminist theorists find in discovering the root cause of women's oppression becomes clearer in the solutions to the problem which they pose. These solutions reveal an inability to discover a social and historical basis for patriarchy. They remain in utopian or idealist dead ends, however much of history's name is invoked.

As Firestone's technological solution to the problem of women's oppression is utopian, so is

Ann Foreman, Femininity As Alienation, London, Pluto Press, 1977, p. 50.

⁸⁶ Ibid.

Mitchell's. She holds that the incest taboo has been rendered irrelevant by the socialization of mankind under capitalism. Therefore no material basis exists any longer for the oppression of women.

"Under capitalism, the mass of mankind, propertyless and working socially together for the first time in the history of civilization would be unlikely, were it not for the preservation of the family to come into proximity with their kin and if they did it wouldn't matter." 87

This is a tenuous basis for social revolution. It is also inconsistent with Mitchell's theory which rests on the dichotomy of patriarchy and economy. It is almost a rhetorical trick to try to reunite the two again, with economy in a dominant position. It is difficult not to see this theory as result orientated. According to Mitchell one is unlikely to come into contact with one's kin, due to the development of capitalism, and this undermines the incest taboo. This is an unlikely basis for overthrowing patriarchy. Mitchell fails to explain how patriarchy, which is passed on through the unconscious

⁸⁷Juliet Mitchell, <u>Psychoanalysis and Feminism</u>, op.cit., p. 380.

outside of class history, gets expunged from human society.

Mitchell goes on to widen the breach between socialist and feminist politics by articulating her grand plan in terms of two separate movements.

Feminists would tackle patriarchal culture, and socialists would tackle the economy.

"The overthrow of the capitalist economy and the political challenge that effects this do not in themselves mean a transformation of patriarchal ideology. This is the implication of the fact that the ideological sphere has a certain autonomy. The change to a socialist economy does not by itself suggest that the end of patriarchy -- a cultural revolution -- is requisite. The battles too must have their own autonomy. It seems to follow that women within revolutionary feminism can be the spearhead of general ideological change as the working class is the agent of the overthrow of the specifically capitalist mode of production."88

This solution does not seem to present new directions. As Zaretsky has stated, this is the present situation. The feminist movement concentrates on the culture and ideology of chauvinism, and the

⁸⁸ Ibid., p. 412.

working class is narrowly economistic:

"After all, a working class movement narrowly concerned with the economy and a feminist movement focused on the culture and ideology of sexism, is what we have now; yet Mitchell puts it forth as a solution."89

Feminist theory has had contradictory impuses.

It recognizes a real social force, patriarchy, but is unable to discern the social process animating this force. Feminist theory thus provides us with a tenuous basis for a critique of patriarchal psychiatry.

It must be emphasized at this point, however, that the feminist social critique has made notable advances in the area of the psychiatric and medical oppression of women. Theorists such as Chesler, 90 Weisstein, 91 and Smith, 92 and Ehrenreich and

⁸⁹Eli Zaretsky, "Male Supremacy and the Unconscious", <u>Socialist Revolution</u>, Vol. 4, No. 3,5, Jan. 1975, p. 51.

Phyllis Chesler, Women and Madness, op.cit; "Women in Psychotherapeutic Relationship", in D. Smith and D. David, Women Look at Psychiatry, op.cit.

Naomi Weisstein, "Psychology Constructs the Female", op.cit.

⁹²Dorothy E. Smith and Sara J. David eds., Women Look at Psychiatry, op.cit.

English 93 have outlined the way in which medicine and psychiatry act to reinforce male supremacism and subjugate woman. Ehrenreich and English note the manner in which medicine interprets the male chauvinist prescription for women's roles as "healthy" or "sick".

"Our social roles and not our innate biology, determine our state of health. Medicine does not invent our social roles, it merely interprets them to us as biological destiny." 94

Chesler says that psychiatry "socially controls the minds and bodies of middle class women via the adjustment-to-marriage ideal and the minds and bodies of poor and single women via psychiatric incarceration; and that most clinicians, like most people in a patriarchal society have deeply antifemale biases..."

Chesler understands patriarchal

Barbara Ehrenreich and Deirdre English, Complaints and Disorders: The Sexual Politics of Sickness, Feminist Press, N.Y., 1973.

^{94&}lt;u>Ibid.</u>, p. 83.

⁹⁵Chesler, "Women in the Psychotherapeutic Relationship", op.cit., p. 384.

society as productive of woman's alienation and unhappiness within the context of family relations. In this context women are supposed to conform to a role which even therapists see as socially undesirable, in Broverman's terms "a most unusual way of describing a mature healthy individual." This contradiction gives rise to alienated behaviour.

Dorothy E. Smith goes further than Chesler, recognizing that as woman's roles are ideological constructs, behaviours which don't "fit" the roles are defined as "pathological". This definition allows psychiatry to avoid the problem of patriarchal role definition and to concentrate solely on distressed individuals. The concentration on the individual in effect bolsters patriarchy by blocking the process whereby the alienated woman sees beyond herself to the patriarchal system as the cause of her distress.

Smith notes that psychiatry organizes women's problems as emotional. This allows the psychiatrist to give the emotional state independent status as a "problem".

⁹⁶ Inge K. Broverman, et.al., "Sex Role Stereotypes and Clinical Judgements of Mental Health", op.cit., p. 5.

This detaches the state from the situation giving rise to it and from possibilities of action. Psychiatry treats the emotional state itself through drugs, etc.

"The behaviour that doesn't fit is treated as a 'symptom'. As a 'symptom' it is understood as pointing to the sickness of the individual. It cannot be related then to her situation." 97

Despite these undoubted advances, the investigators suffer the same limitations as the other feminist theorists examined above. They locate the roots of women's oppression within patriarchy as opposed to class society. Smith comes closest to a class analysis, but nowhere makes this specific.

Therefore Chesler, Smith, et. al. provide excellent empirical analyses of women's oppression by psychiatry. However, they are unable to provide other than intermediary solutions such as increasing the number of female therapists or elaborating a "feminist therapy". I would contend that these solutions remain tenuous by themselves as long as the basis of sex oppression in class society remains in tact.

⁹⁷Dorothy E. Smith, op.cit., p. 5.

All the theoreticians studied thus far view the social differences between the sexes (including mental illness) as rooted outside class history.

Firestone most explicitly connects these differences to biology, but as I have tried to show, Mitchell has been unable to escape biological reductionism. This leads to the posing of vague solutions in terms of cultural revolutions, or outlandish solutions in terms of test tube technology. All such solutions rest on the concept of the will of organized womanhood in feminist movements. These movements will issue vague injunctions to stop the oppression of women, which remain vague without understanding the basis for this oppression.

In actuality, these feminists have not moved much further ahead in theory than the male chauvinists. Both view anatomical differences, translated into psychological structures, as the motive force of culture. The feminists' advance has been to point out that the male chauvinist form of sex differentiation is immoral. The appeal to morality, to a recognition that the inferior status of women contradicts the principles of equality introduced by the French

Revolution, leads to moral solutions - cultural revolutions and the like.

If sex differentiation is rooted in Nature it is very difficult to uproot it. One may uproot Nature with Firestone, or exhort people to rebellion with Mitchell. However neither can explain the material basis upon which people will respond to the feminist challenge. In fact neither can explain why, except as mere idealists, men would want to share in this social transformation. Mitchell vaguely exclaims that "when the feminist movement has a revolutionary theory and practice, men too (if with difficulty) can give up their patriarchal privileges and become feminists." However, men cannot become actual members of the movement "at the level of feminist consciousness... they can only support it in a practical fashion."

Elizabeth Fee has neatly drawn out the difficulty in defining sex as the central human (or

⁹⁸ Juliet Mitchell, Psychoanalysis and Feminism, op.cit., p. 415.

⁹⁹ Ibid.

that matter, ideological/cultural) contradiction. The problem becomes virtually insoluble.

"The difficulty with posing sex as the primary contradiction is that it becomes almost impossible to pose any final solution to the problem: one may suggest the abolition of men but usually without much conviction that such a step would be possible or practicable." 100

I would venture that the method of class analysis poses a viable solution. It comprehends ideology and culture (patriarchy) as an expression of underlying class relations. These class relations have a dynamic and dialectical progress. 101 There are material forces impelling the movement to the overthrow of capitalist class relations and the sex oppression engendered by them. This class struggle is the material class against the oppression of women, which is a force in the armory of capital. The struggle for the liberation of women is thus an inseparable part of the struggle for the abolition of capital.

Elizabeth Fee, "Women and Health Care: A Comparison of Theories", op.cit., p. 402.

¹⁰¹ See David Guest, <u>Dialectical Materialism</u>, N.Y. International Publishers, 1939.

Conclusion

The three theories discussed so far, the medical model of mental illness, labelling theory and feminism, are unable to fully comprehend the nature of women's oppression by psychiatry. The medical model of mental illness is indeed the theoretical vehicle for this oppression; it ideologically constructs the social problems generated by patriarchy as medical problems.

Labelling theory is unable to isolate the root social forces which formulate and enforce mental health definitions. It also fails to situate the labelling process within social history, or more precisely within the history of class struggle. The labelling theorists slip into the error of idealism. Their advance was in questioning the validity of the diagnostic categories and treatment of mental illness.

The feminists, on the other hand, provide a theoretical advance over the labelling theorists.

They clearly locate the definition and control of mental illness within a social context, the context of male domination. Feminism understands psychiatry as acting towards a recognizable social goal, the goal of

preserving patriarchal relations. However, feminism does not locate the roots of female subjugation within the history of class society. It also remains idealist, situating male chauvinism as an attitudinal rather than material problem.

CHAPTER IV

THE PSYCHIATRIC OPPRESSION OF WOMEN

Introduction

Both the labelling and feminist critiques of psychiatric sex oppression are unable to supercede capitalist categories and so remain within the confines of bourgeois ideology.

In this chapter I will elaborate an alternative theoretical framework with which to account for the differential and oppressive treatment of women by psychiatry. My hypothesis is that capitalism shapes and profits from the psychiatric oppression of women.

A materialist perspective views the production of ideas as a social process resting on a material base. The material base for the production of ideas is the same as the material base for the movement of society — the conflict between the forces and relations of production in any given epoch.

¹Karl Marx, A Contribution to the Critique of Political Economy, Moscow, Progress, 1970.

This conflict is given a human form as the struggle between classes. The revolutionary class² achieves dominance and accelerates the development of the productive forces by imposing its stamp on productive relations. The dominance of this class in the social relations of production gives the class hegemony over all phases of social life. At some point the given productive relations act as a brake on the further development of the forces of production and the two increasingly conflict. This conflict appears in the form of social, economic and political crises. The old revolutionary class becomes reactionary and a new revolutionary class arises to restructure the relations of production in its transformation of society. This process continues to the end of the era of class society.4

The ultimate social determinant is then the

The revolutionary class at present is the proletariat, under late feudalism it was the bourgeoisie, etc.

This term is derived from Antonio Gramsci, in Prison Notebooks, N.Y. International Publishers, 1973.

See, amongst others, Karl Marx and Frederick Engels, The Communist Manifesto, Chicago, C.H. Kerr, 1947.

social base which embodies class relations - the economy.

"We make our history ourselves, but in the first place, under very definite assumptions and conditions. Among these the economic ones are ultimately decisive." 5

The struggle between the forces and relations of production, the class struggle, reverberates throughout society in superstructural forms. Social consciousness, morality, science, religion, philosophy, racism, male chauvinism, etc., form part of the social superstructure of society. The economy ultimately decides the superstructure.

The dominant class in any epoch has at its disposal the means of mental and material production. This does not mean that the ruling class' hegemony is insured simply by its ownership of the theatres and printing presses. The very fact that the ruling class rules gives rise to the consciousness, on the part of all members of society, that the ruling class should

Frederick Engels, "Letter to J. Bloch, 1890", in Karl Marx, Frederick Engels, Selected Works, Moscow, Progress 1970, p. 487.

rule, that in fact the way things are, are the way they should be. This consciousness is, of course, not immutable, and becomes less stable with the increasing pace of class conflict and the sharpening of social contradictions.

Antonio Gramsci's definition of the hegemony of the ruling class has been outlined as follows:

"the permeation throughout civil society -- which includes a whole range of structures and activities like trade unions, schools, the mass media, the churches, and the family--of an entire system of values, attitudes, beliefs, morality, that in one way or another supports the established order and ruling class. Hegemony in this sense might be defined as an "organizing principle, " or world view (or combination of such world views), that is diffused by agencies of ideological control (or organically evolves over a long period of time) and is internalized by the general population. . . Insofar as all ruling classes seek to perpetuate their power, wealth, and status, they strive to universalize their own belief systems as part of the "natural order of things."

See Georg Lukacs, <u>History and Class</u> Consciousness, Cambridge, M.I.T. Press, 1972, p. 193.

⁷Carl Boggs, Jr., "Gramsci's Prison Notebooks", Part 1, Socialist Revolution, 12, 1972, p. 98.

In other words, "the ruling ideas of any age are the ideas of its ruling class." All ideas are either those of the ruling class (i.e. in this epoch, capitalist) or of the revolutionary class (in this epoch, the proletariat). Thus social ideas must be analysed in class terms. It is inconceivable that ideas could arise <u>sui generis</u> from interacting groups which are other than class ideas.

of psychiatry which are now organs of the bourgeois state, 9 are unlikely to be other than capitalist ideas unless posed in explicitly revolutionary terms. 10 Even if the chain of causation leading from the psychotherapist in his office to the boardrooms of finance capital is complex and not readily apparent, 11 it must be taken to exist because of the hegemony of the ruling

See Karl Marx and Frederick Engels, The German Ideology, N.Y., International Publishers, 1973, p. 64.

⁹V. Navarro, <u>Medicine Under Capitalism</u>, New York, Predisk, 1976.

Vladimir I. Lenin, What is to be Done? in Selected Works 2, London, Martin Lawrence, 1934, pp. 27-193.

¹¹ Howard S. Becker, op.cit.

class. Those whose actions in any way threaten the hegemonic order of the bourgeoisie are likely to come under the scrutiny of the forces of social control, those forces which maintain the bourgeois order.

The complex and expensive measures of social control applied to women and others serve more than merely symbolic functions. In the context of the struggle between classes, those who disrupt the social order represent a threat to this order. The woman who does not contribute to the stability of the family, who consciously or unconsciously becomes dissatisfied with her "housewife" role, represents a force which needs to be expunged, discredited, or neutralized.

It is the social construction of reality according to the hegemonic ideas of the dominant class which produces rules and deviations from such rules.

Indeed, when someone decides not to wash dishes for days on end, this is not deviant behaviour when considered in a vacuum. When, however, that someone is a middle-aged housewife whose role in the capitalist patriarchal family centres on washing dishes the behaviour is indeed deviant. It must also be noted that the housewife may not be the passive actor

required by labelling theorists (the person on her back in Gouldner's expression). She may be consciously rebelling against the strictures of the patriarchal family relationship. This deviance must be situated within the context of the family and social relations under capitalist hegemony. Furthermore, in crisis periods when the bourgeois class requires maximum social cohesion (eg. the Cold War, 'Sixties' rebellions) it is a necessity for the bourgeoisie to try to prevent oppositional forces from coalescing into outright rebellion. 13

Women became one of the main foci for attention as deviants following World War Two because of the influx of women into the labour force and the increased isolation of the family. 14 These events confronted women with the contradictions in the "housewife" role and at the same time confronted the ruling class with

Alvin W. Gouldner, "The Sociologist as Partisan: Sociology and the Welfare State", The American Sociologist, May 1968, pp. 103-116.

On the Cold War repression, see David Caute, The Great Fear, N.Y., Simon and Schuster, 1979.

E. Zaretsky, <u>Capitalism</u>, the Family and Personal Life, op.cit.

the possibility that women might seek a revolutionary way to redefine their roles. The "mentally ill" - "neurotic" label suited the situation: it fit with the ideological conception of woman as frail or hysterical; it allowed the "neurotic" woman to maintain her housewife role; most importantly it devalued the woman's feelings of distress and alientation and removed the possibility that a criminal label might crystallize these feelings into rebellion. The "neurotic" woman is a major category of deviance today.

The Oppression of Women Under Capitalism

In this section I shall endeavour to outline a theoretical perspective from which to understand the oppression of women in capitalist society. This perspective will be used to comprehend the psychiatric oppression of women. I shall begin by examining the history of the changes in the position of women before and after the capitalist transformation of society. This history appears to indicate that the oppression of women is ultimately decided by economic factors.

At the outset it should be clear that the

feminist location of the family as the prime source of women's oppression raises difficulties. There can be no "family" as such in history any more than there is "society" as such. Family relations are defined by different historical epochs just as productive relations are. It is the same bourgeois ahistoricism asserting the existence of a permanent biologic family which asserts that productive relations throughout history have been relations between managers and workers. Marx points out that the specific economic form for the expropriation of the product of surplus labour in each period determines the corresponding structure of society. I take it that the fluctuations in the form of familial relations also are determined by the economic form.

"The specific economic form, in which unpaid surplus-labour is pumped out of direct producers determines the relationship of rulers and ruled, as it grows directly out of production itself and, in turn reacts upon it as a determining element. Upon this, however, is founded the entire formation of the economic community which gorws up out of the production relations themselves, thereby simultaneously its specific political form. It is always the direct relationship of the owners

of the conditions of production to the direct producers - a relation always naturally corresponding to a definite stage in the development of the methods of labour and thereby its social productivity - which reveals the innermost secret, the hidden basis of the entire social structure, and with it the political form of the relation of sovereignty and dependence, in short, the corresponding form of the state". 15

One can go on from Marx's conception to note that although Nature dictates the necessity for the social production of use values, it does not dictate the social form this production assumes. Similarly if Nature dictates biological differentiation between males and females it does not dictate the social forms and values accorded this differentiation. Nature is merely the context in which sex differentiation is socially translated into sex oppression. The social form of sex differentiation, whether it is oppressive or not, is given by the mode of production of the particular period.

The bourgeois revolution wrought tremendous

Karl Marx, Capital III, N.Y. International Publishers, 1967, p. 791.

changes in family life and the position of women. 16

In pre- and early capitalist society the family was a major productive unit. As capital developed and production became socialized the family was deprived of its primary productive role. As males went out to fulfil productive functions, the female's economic position in the home deteriorated. This revolution continues to this day with housework being unproductive, and women being forced into the arena of social production.

The feudal family was completely integrated into the agricultural economy - the family produced for itself and for the feudal manor. With the rise of commodity production the family still played a major role in the organization of production. The family jointly produced commodities for sale. The wife of the 17th century journeymen was a craftsman as was her husband. In this period males valued marriage, it was a means of enriching themselves. The modern stereotype

See Ann Foreman, Femininity As Alienation, op.cit. and Eli Zaretsky, Capitalism, The Family and Personal Life, op.cit.

of the man having to be coerced into a marital relationship had not yet emerged. ¹⁷ Increasing competition and capitalization disposed the journeyman's family of its means of production. The journeyman was driven into the proletariat. This process quickened with the development of industrial machinery consequent to the socialization of production.

economic and political position. In the U.K., the 1330 Factory Acts restricted the spheres in which women could engage in wage labour. This set the stage for modern sex oppression and the theories of kinder, kuche, kirche. As the family was severed from social production, so the domestic sphere became devalued. The family was no longer a 'social' institution but a 'private' one. The emergence of the modern family concretized the split between public and private life. This is related to a second "split": that between personal life and life within the social division of labour. ¹⁸ The woman has been relegated to the world of

¹⁷ Ann Foreman, Femininity as Alienation, op. cit., p. 88.

¹⁸ This point is explored in Eli Zaretsky, Capitalism, the Family and Personal Life, op.cit.

the private and personal by capital. Her exclusion from the public world of the production of surplus value defines her inferiority. As Engels states:

"the wife became the first domestic servant pushed out of participation in social production." 19

Modern male chauvinism is generated by the divorce of the family from social production in the nineteenth century. The exclusion of women from surplus value production devalued them relative to men. Their role was reduced to supporting men in their "personal" zone; to socializing and reproducing labour power (children); and reconstituting the labour power of the husband through cooking, housekeeping, etc. In the "topsy-turvy world" wherein commodities are accorded human sensibilities, 20 the commodity which can command the greatest exchange - value can also command great social value. Thus the labour-power which is exchanged for a relatively large weekly wage

Frederick Engels, "The Origin of the Family, Private Property and the State", in Karl Marx, Frederick Engels, Selected Works 2, op.cit., p. 247.

²⁰Karl Marx, <u>Capital I</u>, N.Y. International Publishers, 1967, p. 72.

(such as that of doctors, etc.) is considered to hold a "high social status". Since domestic labour-power has no direct exchange-value, the persons who embody that power - housewives - are relegated to the lowest rungs of the "social ladder".

The fact that the housewife does not work for a wage renders her economically dependent on her husband and replicates, in miniature, bourgeois relations of production within the household. The distribution of the husband's wage is a "private matter" between husband and wife. He "gives" her money and she must "ask" for raises. 21 "In the family, he is the bourgeois, the wife represents the proletariat." 22

Thus the development of capitalism isolated women from surplus-value production in the home where they provide unremunerated services for capital.

Furthermore by this division, capital was able to restructure the family in its own image. The rise of

See Wally Seccombe, "The Housewife and Her Labour Under Capitalism", in New Left Review, #83, Jan-Feb., 1973, pp. 3-24.

²² Frederick Engels, "The Origin of The Family, Private Property and the State", op.cit., p. 247.

feminist theory has given rise to an interesting and useful debate as to whether the housewife's labour is productive, in the Marxist sense. I shall only make note of the existence of this debate here. However, there can be no productive labour, to my mind, without the production of surplus value. This would seem to dictate a number of conditions absent from domestic production, among which are the exchange of such use of labour power for a wage, and the production of commodities which can be alienated for a price. Housework creates use-values alone.

The discussion of women's oppression cannot end here, however. Despite patriarchal ideology over the past half century a woman's place has increasingly come to be in the factory, not just the home. This is an extremely important development for the purposes of the present paper. This breach between the ideology of the "woman's place in the home" and the reality of

Wally Seccombe, "The Housewife and Her Labour Under Capitalism", op.cit., Jean Gardiner, "Women's Domestic Labour" in New Left Review #89, and Margaret Coulson, Branka Magas and Hilary Wainwright, "The Housewife and Her Labour Under Capitalism - a Critique" in Ibid., (plus numerous replies).

increasing numbers of working women, it appears to me, has created psychiatry's mandate to buttress an ideology with a disappearing material base. It has further created the alienation of those women, mostly middle-aged housewives, ²⁴ who remain in the home.

Although capital has profited by keeping women at home, contradictory forces in the social development of capital tend towards the increasing proletarianization of the population. This tendency has led to the proletarianization of the housewife. Economic necessity has driven the woman to seek a wage, as economic forces expanded the social forces of production necessitating the inclusion of women in social labour. This points out the basis for the rise of feminism. Even though the feminists deny the existence of capital as a prime social mover, the development of capital itself, in eroding the material base for male chauvinist ideology, has created the

Pauline Bart, "Depression in Middle-Aged Housewives", Women in Sexist Society, op.cit.

²⁵See Karl Marx <u>Capital I</u>, <u>op.cit.</u>, especially, <u>inter alia</u> "Historical Tendency of Capitalist Accumulation", pp. 761-766.

conditions which allow 20th century feminism to flourish.

After all, if sex oppression is not determined by class relations, what prevented the emergence of feminism many centuries ago?

William Chafe²⁶ has noted the dramatic changes in women's participation in the work force in twentieth century America. The First World War brought women into industry, followed by a stready rise in the percentage of employed women up to the Second World War. The most dramatic increase occurred during and after the Second World War. Whereas at the turn of the century wage labour was largely the preserve of unmarried women, by the 1970's the majority of married women held jobs.

The Second World War was a watershed in the entry of women into the labour force. In the United States over 6 million women took jobs. This increased the size of the female labour force by 50%. 27 In Canada

William Chafe, The American Woman: Her Changing Social, Economic, and Political Roles, 1920-1970, N.Y., Oxford University Press, 1974.

²⁷ Ibid., p. 125.

in 1939, 144,000 women were in factory and industrial work, by 1943 this number had risen to 255,000 in war work alone. The proletarianization of women reached into the family. In the United States in 1940, 15.2% of married women worked. By 1945 this percentage rose to 24%. Thirty percent of the female labour force was married with husband present in 1940. This figure rose to 58% by 1974. 29

In Canada between 1941 and 1951 the number of middle-aged women (35-44 years old) working rose from 18% to 22% of the labour force. In the 45-54 age range the figures are 15% and 21% respectively. The United States workforce was 20% female in 1900, and 44% female in 1972. Similarly, in Canada the workforce was 16%

Cited in Carol Schmid, "The 'Changing' Status of Women in the United States and Canada", in Marylee Stephenson (ed.), Occasional Papers of The McMaster University Sociology of Women Programme, #1, Spring, 1977, p. 251.

²⁹U.S. Bureau of the Census, The Statistical History of the United States from Colonial Times to the Present, Conn., Fairfield Pubs., 1975, p. 72.

³⁰ Sylvia Ostry, The Female Worker in Canada, 1961 Census Monograph Series, Ottawa, Dominion Bureau of Statistics, 1968, p. 3.

female in 1900 and 38% female in 1972. 31 The British position was exactly equivalent. "Consequently, the growing phenomenon of the working woman threw into crisis the entire female stereotype. "32 This crisis gave birth to feminism. Barbara Easton notes that at the time when the patriarchal family was being most underminied by the entry of women into wage-labour, feminists began their single-minded assault on patriarchy. 33 Barbara Easton argues that feminist writers have not deeply examined the historic changes in the family under capitalism because this would render their insistence on attacking patriarchy irrelevant. It is intriguing to note that early feminists (suffragettes, etc.) concentrated on 'political' questions, whereas the feminists of the 1960's concentrated on the family and personal life, thus reflecting the actual weakening of the family.

Carol Schmid, "The 'Changing' Status of Women in the United States and Canada", op.cit., p. 260.

³²Ann Foreman, Femininity as Alienation, op.cit., p. 128.

³³ Barbara Easton, "The Decline of Patriarchy and Rise of Feminism: A Critique of Feminist Theory", in Catalyst 10-11, Summer 1977, pp. 104-124.

If patriarchy has been undermined by capitalism, why does it remain? I would argue that patriarchy has not faded away because it performs a useful function for capital. Capital injects male chauvinism with new 'blood' through psychiatric ideology, bourgeois cultural transmissions, etc., in order to assist in the production of maximum profits. The median wage for full-time Canadian female workers in 1975 was only 37% that of male workers. Although a higher proportion of women than men worked part-time when the yearly wages of both are averaged in, women made only 44% of the amount men received. 34 Women have a higher official unemployment rate than men but it is clear that the disparity would be even greater if the 'official' statistics took into account those who have given up looking for a job and remain at home. Thus much of the total social profit derives from sexual wage differentials. The preservation of male chauvinist ideology then serves the bourgeoisie in its quest to

³⁴ Statistics Canada, Income Distribution By Size in Canada, Cat. #13206, 1975.

extract superprofits from female labour. It further serves to divide the working class organizationally and psychologically. The fact that male workers allow female workers to be exploited at a higher rate weakens the ability of the working class as a whole to unite to secure a larger proportion of social wealth. In regards to psychiatry and the family, the chauvinist ideology which sanctifies the oppressed position of the housewife also structures the home as a control institution to house the woman excluded from wage labour (or property ownership). Capital benefits from male chauvinsim. 35

My thesis is that patriarchy cannot be considered a wholly autonomous area with a seperable internal mechanism from the dynamics of the historical mode of production. That is, modern patriarchy is

³⁵ See Charnie Guettel, Marxism and Feminism, Toronto Women's Press, 1975.

fashioned by modern capitalism. 36 The family itself has been fundamentally altered by the development of capitalist production. The modern patriarchal family

Before closing this section I wish to address a couple of minor points. Firstly, the removel of the economy as the central determinant of human society leads feminism back towards simple bourgeois pluralism. Thus the solutions posed to the problem of women's oppression, even when couched in "revolutionary" terms, are in fact liberal and idealist. They boil down to efforts to convince people that oppression is unfair.

Secondly, although I have attempted to explain how women's roles develop on the basis of class relations, I should answer the charge that socialism has not brought about the liberation of women. feminists misread Marx to say that socialist revolution will automatically emancipate women. (For example, Shulamith Firestone, The Dialectic of Sex, op.cit., amongst many others.) No self respecting Marxist has ever argued this. All call for class struggle against bourgeois ideologies and practices both before and after the seizure of power by the proletariat. Marx, Frederick Engels, Vladimir Lenin, and Joseph Stalin, On the Woman Question, N.Y. International Pubs., 1952.) The argument that since Marx did not call for a struggle against male supremacism the revolutionaries did not bother to struggle, sets up a straw man to demolish. Furthermore, I would argue that socialism has led to appreciable gains in the position of women. (Seema Allan, Women in the Soviet Union, London, Left Book Club, 1938.) In addition many present-day self proclaimed socialist societies are not socialist, but varieities of capitalism. The fact that the position of women is eroding in such societies is testimony to their revisionism. (On the question of state capitalism in the Soviet Union, see Martin Nicolaus, The Restoration of Capitalism in the USSR, Chicago, Liberator Press, 1976, and for China see Enver Hoxha, Imperialism and the Revolution, San Francisco, World View, 1979.)

is predicated on the divorce of women from the means of production. The family has been converted into a "private" zone wherein the woman, for no remuneration, reproduces, socializes and reconstitutes labour power in the form of husband and children. This is an invaluable service for capital.

A contradictory development, also conditioned by the evolution of capitalism, has undermined the 'housewife' role and sent women into the field of wage labour. This development has allowed the birth of feminism, which is predicated on the contradiction between the 'housewife' and 'worker' roles of women. However, patriarchy has accompanied the increasing entry of women into the labour force. This has meant that working women are given lower wages than men, and are politically, socially and psychologically separated from them. This process serves capital by fracturing the unity of the working class and providing excess profit through wage differentials.

Modern patriarchy is not understandable other than as a function of capitalist development. Its form and content, within and without the family, change with the changes in the mode of production.

Psychiatry

It is necessary now to examine psychiatry.

To this point it has been demonstrated that psychiatric practice discriminates between males and females.

Furthermore, that there is corresponding sex discrimination in society in general. How then does psychiatry come to operate with sex differentials?

Before attempting to answer this question it is necessary to locate psychiatry within the present social order. What is the role of psychiatry under capitalism? How has it developed?

The oppression of women by psychiatry^{37a} rests on a medical ideological base. That is, psychiatry, as a branch of medicine, perceives women's problems as the result of "illness" rather than as the result of

³⁷a In this thesis I am restricting my inquiry to traditional, or mainstream psychiatry. I am aware of the existence of numerous radical, feminist, gestalt, group and other therapies. However, it is my contention that these therapies will be unable to advance: (a) without rejecting individualist notions of "illness" causation and (b) without radical change in the social formation, which otherwise protects and promotes bourgeois psychiatry. Even with rejection of psychiatric individualism, these therapies remain fringe phenomena, unable to compete with the large machinery of the psychiatric establishment.

social contradictions. Taking its cue from the medical model of mental illness, psychiatry sees the roots of the illness in the affected individual. The "cure" is then brought about by somehow altering the individual. To affect this alteration psychiatry uses medical and non-medical methods, ranging from surgery and drugs, to behaviour therapy, etc.

The question of how the treatment of social problems such as neurosis or madness came to rest in the hands of the individualist psychiatrist is a complex historical matter. I do not intend to provide the answer to that question in this paper. The what follows then are some hypothetical and partial explanations for the rise of modern psychiatry.

At the outset one would expect that the mechanisms of social control under capitalism would have to be theoretically grounded in science. Science was the necessary condition for the nurturance of

Some keys to this problem may be found in Michel Foucault, Madness and Civilization, N.Y. Random House, 1965.

capital. 38 Capital depends for its very existence on the constant revolutionizing of the means of production. The scientific revolution consequent to the bourgeois revolution undermined all earlier metaphysics, religion and mysticism. 39 Therefore it is unlikely that capitalist social control could develop other than on a scientific basis. With the bourgeois revolution came the sciences of penology, criminology, psychology and psychiatry. 40

These disciplines developed with the growth of expropriated sectors of the population who were excluded from both the ownership of property and wage labour. These sectors, the mad, the unemployed, the beggars and thieves, were further excluded from society by confinement in institutions. This confinement began in the seventeenth century. The institutions provided a source of cheap labour for the early accumulation of capital.

³⁸Frederick Engels, Anti-Duhring, Moscow, Progress Publishers, 1970.

³⁹ Ibid.

⁴⁰ See I. Taylor, op.cit.

⁴¹ Foucault, Madness and Civilization, op.cit.

The increasing specialization of functions which characterizes the capitalist division of labour led to the separation of the mad and the criminal in the 19th century. 42 This separation presumably occurred on the foundation of individualist principles of guilt and volition. The criminal voluntarily ("mens rea") committed anti-social acts and was confined to consider the morality of his position and repent. The involuntary madman was similary confined in a structured environment where he could be manipulated by various techniques into a cathartic confrontation with his madness.

Both institutional environments replicated the social relations of the factory society. The inmates were subject to minute and precise forms of control. Their schedules were rigidly timed, they were watched, studied and calibrated infinitesimally. 43 These procedures rested on the bourgeois passion for measurement and exactitude, both concomitants of the

⁴² Ibid.

Michel Foucault, Discipline and Punish, N.Y., Pantheon Books, 1977, and Madness and Civilization, op.cit.

precision required by socialized and mechanized production ⁴⁴. Prisons and asylums were mass institutions which contained complex bureaucratic apparatuses of control, mirroring the class relations of domination and subordination in the outside world.

The mechanisms of control vary with the mode of production. Feudalism calls forth the spectacular, grotesque punishment such as mutilation, which reaffirms the awesome power of the sovereign. Capitalism engenders an entirely new mode of control, a disciplinary mode. This mode has as its aim the disciplining of deviants into docile bodies, essential cogs in the complex and precise mechanisms of capitalist production. Capitalism requires a disciplinary paradigm, an overarching social sense of obedience, disciplined habits and schedules. Psychiatry is part of the disciplinary mechanism of capitalism just as the executioner was part of the punitive mechanism of feudalism. Psychiatry acts to reinforce discipline by studiously measuring, watching and indexing the deviants who must be returned to the

⁴⁴ Karl Marx, Capital, vol. 1, op.cit.

disciplined fold. 45

While the lawyers, police and judiciary controlled the prisons, doctors were left in charge of the asylums. The doctors thus began their subspeciality, the preoccupation with the mind. It must be noted that the asylum and the prison, never far from one another in concept, have recently drawn very closely together again. This time prisons resemble asylums, and prisoners are "treated" psychiatrically instead of being treated to simple punishment. 46

Alcoholics, homosexuals and mass murders became "sick" not "criminal".

It is possible that the bourgeois conception of individual will, guilt and responsibility, fashioned by the liberal vision of society as a collection of freely contracting individuals, presaged the disease model of mental illness. The disease model (as opposed to the crime model) focuses on involuntarily acquired

Michel Foucault, Discipline and Punish, op.cit.

⁴⁶ Richard Speigleman, "Prison Psychiatrists and Drugs: A Case Study" in Crime and Social Justice, 7, Spring-Summer 1977, pp. 23-39.

states.

The other institution to become instrumental in the formation of modern psychiatry was the family. The bourgeois family, like the asylum or prison, is a control institution housing those excluded from wage labour, in this case, housewives. 47 Between the feudal and the capitalist epochs, the structure and functions of the family underwent a radical transformation. longer was the family a primary productive unit. fact the familial means of production were expropriated and the family was cut off from social processes of production and exchange. 48 The totality of social roles assumed by the family greatly contracted. The family became isolated and privatized. 49 With the advent of capitalism, the family became the focus for initial socialization and personal emotional problems which were suppressed in the rationalized world of productive labour.

Personal Life, op.cit.

Ann Foreman, Femininity as Alienation, London, Pluto Press, 1977.

⁴⁹ Zaretsky, ibid.

As men went out to work, women lost their major productive roles and were relegated to household production, the reproduction of children and the regulation of personal relations in the "non-work" world. The woman became the heart of the family's refuge from the world of social production.

At the point where the family is finally set adrift from the process of production (after being a venue of commodity production in the early capitalist period) it began to be investigated as a separate entity. The family had remained as an important factor in the bourgeois pantheon: church school, police, family, state. Psychoanalysts and psychiatrists began to peer at the family to insure its delicate emotional balance. Description of the popular phenomenon until, at the earliest, midway between the two world wars. I suggest that

⁵⁰ Zaretsky, ibid.

^{51&}lt;sub>B.P.</sub> Dohrenwend and B.S. Dohrenwend, "Sex Differences and Psychiatric Disorders," American Journal of Sociology, Vol. 81, #6, May 1976, p. 1448; Aldwyn Stokes, "The Evolution of Clinical Psychiatry", American Journal of Psychiatry, 126: 1, July 1969, pp. 138-140.

one reason for this must be found in the increasing contradiction arising in the patriarchal family as a result of the large-scale entry of women into the labour force. The process of the proletarianization of housewives seriously undermined the "housewife" role and led to the increasing discomfiture of women with their roles. The bourgeois family came under stress from the inevitable development of bourgeois production. Precisely when women began to participate in the work force, psychiatry intervened in the family to deal with those women excluded from wage labour. The majority of women who come in for psychiatric attention are middle aged housewives. ⁵² Psychiatry had little problem then focussing its attention on other marginal sectors of society, prisoners, the unemployed, etc.

I believe that the key to understanding the reason why psychiatry came to be the force which attempted to stabilize non-working women in their anachronistic roles is a statement by Walter Freeman. dean of U.S. lobotomy. Freeman once stated that lobotomized women make good housewives. After all it

⁵² Pauline Bart, op.cit.

doesn't take much "for a wife to keep house". 53
Criminalizing distressed or rebellious females
unnecessarily removes them from the family and runs
the risk of heightening the distress. A woman
conscious of being repressed at home may have this
consciousness sharpened by action by recognized agents
of control, the police. It is different however, with
less obvious agents of control, psychiatrists.
Furthermore, the psychiatrist deals with involuntary,
sick behaviour. To so define the behaviour of the
alienated female is to discredit it, thereby removing
the possibility of collective rebellion. The behaviour
is viewed as an individual, isolated problem.

Since the ruling social ideas derive from the ruling class, psychiatric definitions accommodate the social standards of capital. Psychiatry thus reflects the values of capitalism, inclusive of class bias, racism and male chauvinsim. Psychiatry in fact acts to obfuscate the existence of male chauvinism, etc.

⁵³Cited in A U.C.L.A. Centre for Psychosurgery? op.cit., p. 3.

"Racism, sexism, exploitation, and imperialism disappear, save as triggers of latent psychopathology. Conceived of in scholarly journals, boiled down by pop psychiatrists, advice columnists, and consultants, therapy has become the pseudoscientific underpinning for a repressive ideology that promotes alienation from oneself, from others, and from reality."54

Psychiatry is both integrated into, and, reciprocally legitimized by the modern capitalist state apparatus. 55 Marxists hold that the present state is the executive committee of the ruling class. 56 Its function being to ensure capital accumulation, to ameliorate disputes between sections of the ruling class, usually at the expense of the weaker sections,

M. Glenn and R. Kunnes, Repression or Revolution?, New York, Harper and Row, 1973, p. 56.

^{55&}lt;sub>v. Navarro, op.cit.</sub>

^{56 &}quot;The executive of the Modern State is nothing but a committee for managing the common affairs of the whole bourgeoisie." K. Marx, F. Engels, The Communist Manifesto, Chicago, C.H. Kerr & Co., 1947. The other sources which I take as the bedrock of my analysis are: N. Poulantzas, Political Power and Social Classes, London, NLB, 1973; N. Poulantzas, Classes in Contemporary Capitalism, London, NLB, 1975, V.I. Lenin, The State and Revolution, New York, International Pubs., 1932.

and, in struggles between capital and labour, to enact reforms which leave the dominance of capital intact. 57

The function of the state primarily as ensurer of capital accumulation can be clearly seen in view of the fact that under monopoly capitalism, all phases of activity of the state turn on its intervention in the economy. That is, questions such as broadening democracy, funding social service sectors, taxation, et al become subsumed under questions of GNP, trade balance, etc. The more depressed the economy, the more open are efforts to increase state repression, cut social services, and increase direct intervention in industry.

Psychiatry is directly and indirectly integrated in the capitalist state. Its organizations, institutions and training facilities are sanctioned and funded through state resources. Its internal organization replicates the class relations existent in monopolist capitalism, i.e. there are rigid

⁵⁷ See, in addition to Poulantzas, M. Godelier, Rationality and Irrationality in Economics, N.Y., Monthly Review Press, 1973.

hierarchies with administrators at top and technocrats, (consultants, etc.) in high positions. Patients are the "proletarians" of the system - blamed for the system's inadequacies, exploited as consumers of medical products.

One clear example of the exploitation of the patient as consumer and reciprocally the interconnections between psychiatric practice and corporate capital is that of the drug industry. The drug industry has a large stake in the maintenance of current prescribing practices. In the United Kingdom in 1971 drug companies spent 33 million pounds on advertising. ⁵⁸ More money is spent in the U.K. and the U.S. on drug advertising per doctor than was spent to train that doctor in the first place. In the U.S. in 1971 the drug industry spent \$5,000 per doctor on advertising. ⁵⁹ In Canada advertising expenses of the drug industry in 1977 amounted to about \$35 million, or about \$1,000 per doctor in Canada. Since this

^{58 &}quot;The Drug Companies", Workers Research Unit Bulletin, op.cit., p. 27.

⁵⁹ Ibid.

figure is not inclusive of promotional parties, free samples, etc. the figure is probably closer to \$3,000 per doctor, still below the U.S. figure. 60

The industry does indeed find the sale of drugs profitable enough to invest such huge sums in advertising. Roche's annual profits from Valium and Librium worldwide are \$100 million. 10 In the U.S. in 1972 Roche's revenues from the drugs amounted to \$300 million. 20 Sternbach, Valium's inventor, estimates that 1978 sales of Valium and Librium amount to \$500 million in the U.S. alone. 30 Canadian figures are difficult to obtain, but Valium sales (Valium is only one of twenty brands of diazepam in Canada) amounted to \$5½ million in 1977, according to the company. 44

The world market for sales of pharmaceuticals in 1970 was roughly \$18,000 million. By 1980 it is

⁶⁰J. Doig, op.cit., p. 5.

R. Ball, "The secret life of Hoffmann-La Roche", Fortune, August, 1971, pp. 130-134.

⁶² Subcommittee on Health, Committee on Labor and Public Welfare, United States Senate, op.cit.

⁶³E. Drobot, op.cit., p. 14.

^{64&}lt;u>Ibid.</u>, p. 15.

\$50,000 million. The largest pharmaceutical producer is the U.S. 65 This money has given the drug industry inordinate power. Drug advertising forms the major portion of the revenue for such journals as the Journal of the American Medical Association and the industry forced the termination of the AMA's independent drug evaluation programme. Further, the industry seems able to affect the Journal's editorial policy. The industry also readily uses its power to counter regulation by the U.S. Congress and Food and Drug Administration. 66

The drug industry is thus able to influence the behaviour of practitioners. It may be said that the relationship between the industry and the practitioner is symbiotic. The medical model of mental illness sanctifies the prescribing habits preferred by the drug industry. In addition to situating the individual rather than the system as the guilty party

^{65 &}quot;The Drug Companies", Worker Research Unit Bulletin, op.cit., p. 26.

⁶⁶M. Silverman and P.R. Lee, <u>Pills, Profits</u> and Politics, op.cit., pp. 34 and 68-72.

in generating "sickness", the practice of psychiatry in integrated as a profit producing mechanism in the system.

This holds true for all branches of medicine, not just psychiatry. Furthermore, the medical model of individual dysfunction absolves the system from blame in cases of physical, as well as psychosomatic distress. However, there are differences between "physical" and "mental" medicine.

The capitalist state needs to incorporate "mental health care" as another mechanism in its arsenal of social control.

"The state has assumed most of the traditional social functions of regulating and controlling human conduct. Because all moral codes are not codified in law, and because the power of the state is limited by rule of law, the state is unable satisfactorily to control and influence individuals. This requires a new social institution that, under the auspices of an acceptable modern authority, can control and quide conduct without conspicuously violating publicly avowed ideals of freedom and respect for the individual. Psychiatry, in medical disguise, has assumed this historical function. Psychiatry is (thus) social action disquised as medical treatment. use of the medical model shields us

from embarrassing facts about our society and its methods of social control. It also impedes our understanding them - psychiatry should abandon its medical mask."67

capital allows psychiatry power because psychiatry is a creation of capital, and because it has been outfitted in "professional" guise.

Professionalism is an interesting feature of modern capitalism. Capital recruits intellectuals who are not organically part of the ruling class, but who perform indispensible functions for this class. These intellectuals are given special status and powers and are allowed to retain some internal control over their work. This is attained through the creation of professional associations, the modern equivalent of feudal guilds. The professions retain peer review, and highly individualized and mystified definitions of quality and work. Gramsci notes that:

"Since these various categories of traditional intellectuals experience through an "esprit de corps" their uninterrupted historical continity and their special qualification, they thus put themselves forward as

⁶⁷R. Leifer, "The Medical Model as Ideology", Int. Journ. Psychiat. 9: 13-21, 1970.

autonomous and independent of
the dominant social group. This
self-assessment is not without
consequences in the ideological and
political field, consequences of
wide-ranging import. The whole of
idealist philosophy can easily be
connected with this position assumed
by the social complex of intellectuals
and can be defined as the expression
of that social utopia by which the
intellectuals think of themselves as
'independent', autonomous, endowed
with a character of their own, etc."68

Gramsci's observation that the intellectuals perceive themselves as an autonomous group is important. It allows the obfuscation of the role of capital both in the mind of the public, and in the mind of the professional himself. This further enhances the position of the professional and adds to his privilege. Gramsci also notes the recruitment of such intellectuals from strata likely to be loyal to the dominant class.

"It is worth noting that the elaboration of intellectual strata in concrete reality does not take place on the terrain of abstract democracy but in accordance with very concrete traditional historical processes. Strata have grown up

⁶⁸Antonio Gramsci, <u>Prison Notebooks</u>, <u>op.cit.</u>, pp. 7,8.

which traditional 'produce' intellectuals and these strata coincide with those which have specialised in 'saving', i.e. the petty and middle landed bourgeoisie and certain strata of the petty and middle urban bourgeoisie."69

This common class origin is quite evident for doctors. Those few who are not petit bourgeois by origin gradually become socialized into that class through specialized training, the educational system, and work-place structures and norms. 70 The professional is not immediately likely to examine and question his role in the division of labour of capitalist social control functions.

The petit bourgeois position of the professional and the prestige and autonomy accorded him, ideally place him for the relations of domination—subordination that characterize doctor—patient inter—action. In fact, in line with the chauvinsim of the practitioners, patients in therapy are encouraged to experience "transference" and to view their therapists as father—substitute. The doctor controls the patient

⁶⁹ Ibid., p. 11.

⁷⁰ See V. Navarro, op.cit.

whom he sees as a disembodied collection of symptoms. 71
The repressive nature of his treatment (sometimes killing the patient or destroying her mental capacities) is again hidden in the guise of medical intervention. The pills are sometimes bitter, but necessary.

So the psychiatrist is an agent of bourgeois social control. He reinforces the racial, sexual and class inequalities of bourgeois society by ignoring their importance (or existence) in triggering human problem reactions. His specialty is characterized by relations of control and domination within the framework of the overarching relations of control and domination defining bourgeois society. Psychiatry is the mystification of social relations by mystified practitioners.

⁷¹ Freud stated that the therapist-patient relationship was one of a "superior and a subordinate", Sigmund Feud, "On the History of the Psycho-analytic Movement" cited in Phyllis Chesler, "Patient and Patriarch: Women in the Psychotherapeutic Relationship" in V. Gornick and B.K. Moran, eds., Woman in Sexist Society, op.cit., p. 375.

Conclusion

Since my thesis rests on the observation that the economic base is the determinant "in the final instance" of social relations, it has been my intent in the foregoing to demonstrate that psychiatry is determined by this economic base. Psychiatry thus serves capital. Inasmuch as capital depends on patriarchal relations, it is unremarkable that psychiatry upholds these relations. As feminism arises as a liberating political force in the contradiction between female wage-labour and family, so does psychiatry. Psychiatry approaches this contradiction from the other direction, so to speak. Instead of protesting against the position of women, it attempts to resolve the contradiction on the side of reaction. That is, psychiatry assumes that the 'housewife' role is the natural role of women. Psychiatry attempts to turn the clock back to the period before the entry of women into the wage-labour force.

In using the benchmark of the happy 'housewife', psychiatry's mandate is to force women into this mold, by psychotherapy, drugs, shock and psychosurgery. These

are in fact the psychiatric machines of force against the liberation of women.

CONCLUSION

This study has examined differential diagnosis and treatment in psychiatry generated by sex differences. It attempted to explain why women are diagnosed and treated differently from men and what this tells us about the nature of psychiatry.

The problem presents itself in the current rise in the use of drastic techniques of behaviour modification, for example the use of psychosurgery, electroconvulsive therapy, and psycho-chemotherapy. These techniques clearly are massive assaults on the personality, yet they are used on large numbers of women suffering from mental problems defined as minor, such as neurosis.

Since the evidence tends to demonstrate that
the only clearly proven effect of the techniques
mentioned is to subdue and control people, I contend
that this is the main basis of the psychiatric treatment
of women. That is, psychiatry acts to subdue and
control women who are alienated or rebellious, defined
as neurotic. This control is not exercised in a vaccum,
but it is a form of bourgeois social control. Its'

effect is to maintain the capitalist status quo in the quise of medical treatment.

The thesis has been divided into three parts, first, an analysis of the data on diagnosis and treatment of mental illness, so called. Secondly, an analysis of the theories which attempt to account for the phenomenon of psychiatric control. Finally I attempted to evolve a theoretical framework which superceded the inadequacies of the other theoretical approaches.

My first task was to analyse the available data on diagnostic categories and treatments, broken down by sex. The data on admissions to mental institutions indicates that women receive differential diagnoses and treatments in comparison with men. The category of "neurosis" accounts for 68% of female first admissions into mental hospitals. This category is one which has no etiology based on organic foundations. Men, on the other hand most often appear in categories which do have a direct organic etiology, for example alcoholic psychosis.

The problem that the data presents is sharpened

if one examines the cloudy nature of the "neurosis" category (this is just one example of psychiatric vagueness in definitions). There is no single definition of neurosis, different psychiatrists have different definitions. All have one aspect in common; they are vague enough to allow any subjective definition. I contend that this definition will be based on the psychiatrist's (and psychiatry's) view of normality and abnormality and this view will be based on the status quo.

However, once the woman is so defined, as "neurotic", she is subjected to severe "treatments".

The treatments recommended for neurosis include psychosurgery, psychochemotherapy and electroshock.

I have chosen these treatments because they
most starkly delineate the problems inherent in
psychiatric social control. ECT and drug therapy are
in very widespread use, psychosurgery is resurging now.

All three treatments are used mainly on neurotics and this infers women. As has been demonstrated: three times as many women as men receive shock treatment; two to three times as many women consume tranquilizers;

and three quarters of all psycho-surgical operations have been done on women (both past and present).

All three treatments have poor success rates.

They neither "cure" nor alleviate "symptoms". ECT

studies indicate that there is no significant difference
in the rate of improvement between one group of patients
give ECT and a matched group without ECT. Drug studies
demonstrate little difference in rates of improvement
between tranquilizer and placebo users, especially in
terms of prolonged usage. Psychosurgery success
rates must be viewed with suspicion.

This point is critical. The treatments do not successfully "treat". In fact they produce a host of unwelcome side effects which could be viewed as "symptoms" in their own right. ECT's most common side-effects are memory loss, impairment of learning ability, irreversible brain damage. Drugs such as valium and librium (the most frequently prescribed drugs in North America) include in their lengthy list of side effects: drowsiness, confusion, muscular incoordination, decreased scores on intelligence tests, double vision, tremors, anxiety, hallucinations, birth defects and

addiction. Psychosurgery renders people apathetic, irresponsible, asocial, with intellect and emotions blunted, judgement impaired, creativity reduced.

However, despite the lack of success in treatment, these three techniques do have one common effect, they render the subject more quiet, more docile, more amenable to control and less rebellious.

Women are the particular focus for control through psychosurgery et al. Rather than alter pathogenic family environments, or changing the oppressive roles allotted to women, these treatments anaesthetize women to their surroundings. "Lobotomized women make good housewives". As has been pointed out, brain damaged women can perform their traditional social roles more easily then men in the same condition.

The question remains as to why women are diagnosed as neurotic and subsequently receive such drastic treatments? I examined three theories which attempt to answer this. The first theory is the psychiatric theory. The traditional psychiatric rationale for the physical treatment of mental illness is the medical model of mental illness.

This model proposes that psychological -

behavioural problems are to be seen as symptomatic of underlying medical disorders. Traditional psychiatry holds that brain disease is the source of personality problems. The psychiatrist thus proceeds to affect or operate on the brain with various techniques.

However, the "personality" is enmeshed in a constellation of determinants, among which the social and the economic in particular are primary.

The medical model of mental illness abstracts the individual from the social environment and attempts to discover the roots of alienation within the individual. Because of its ignorance of the social contradictions generating "neuroses", psychiatry upholds the existing social order.

Following this logic, since social contradictions are ignored as determinants by psychiatry, the contradictions in society are upheld as "normality". Thus the male chauvinist prescription for female behaviour is the psychiatric definition of normalcy.

The labelling theorists attempted to radically criticize the medical model of mental illness. The Labelling school is also known as the "societal

reaction" school because of its emphasis on societal reaction as the generator of deviance.

Labelling theory concentrates on the process whereby the "labelled" individual alters his self image and accepts his stigmatized role following the social reaction to the "label". Labelling theory is unable to uncover the root of psychiatric sex discrimination. It remains trapped at the level of appearances "labels". It criticizes the "label" without comprehending the class forces which define reality and the labels themselves. It is unable to grasp the social dynamic which produces the distressed, rebellious or alienated behaviours which call forth labelling.

The last theory I chose to examine is Feminism.

While avoiding some of the pitfalls of labelling theory
and evolving a more radical critique of women's oppression,
feminism has not underlined the economic and historical
roots of the phenomenon. Feminism is idealist and
ahistorical. Its central error has been to separate
class and women's struggles.

Feminism located the essence of women's oppression within patriarchy. However this factor itself is determined by the development of class

relations. Thus feminism remains confronted with universal sex oppression and little prospects for overturning this condition. Furthermore, the growth of feminism itself is conditioned by class struggle, the proletarianization of women in particular.

I would argue that women's oppression is generated by capitalism. Similarly, that psychiatry operates according to the imperatives of modern capitalism. It functions to control those who are oppressed and to neutralize or destroy their capacity to resist. Psychiatry mainly confronts those sectors which are excluded from the wage labour force and present a potential threat to the stability of bourgeois society. Women are the great focus for psychiatric action.

Psychiatry functions to control those who are oppressed and to neutralize or destroy their capacity to resist. Psychiatry mainly confronts those sectors which are excluded from the wage labour force and present a potential threat to the stability of bourgeois society. Women are the great focus for psychiatric action.

Psychiatry acts to control those who have no

social power within the productive process. The powerless sectors are described as acting without volition, prey to the forces of disease and madness lurking around them. They lack the purposiveness of the bourgeoisie or the proletariat. They are to be controlled as involuntary actors.

Psychiatry specifically concentrates on those who have no direct connection with socialized labour — middle aged housewives. These women perform an essential function in maintaining the viability of the family, an institution integral to the functioning of capitalism. However, their labour is not valued and since the Second World War, the conflicts generated by the housewife role have become more sharply visible. Fluctuations in the composition of the labour force during and following the War drew huge numbers of women in and out of factory work in a bewilderingly short space of time. This inevitably undermined traditional notions of women's roles in the home. Psychiatrists had to cope with the distress and alienation felt by women whose roles fit less snugly.

The psychiatric response defined the social problem of women's exclusion from the world of "real

work" as an individual problem among women. Psychiatry relocated the problem from the arena of the class struggle into the innermost reaches of the mind.

Psychiatry had to convince women that the contradiction between the housewife and proletarian roles lay in their heads, not in the social reality of capitalism. Following this it had to act to resolve the contradiction, while purposefully leaving the social contradictions intact. Psychiatry upholds the rule of capital and the oppression of women.

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